MENTAL HYGIENE

VOL. XXXIII APRIL, 1949 NO. 2

RESENTMENT: AN OBSTACLE TO REËDUCATION

DR. O. L. FOREL
St. Prex, Switzerland

REALIZATION of the collective responsibility for two world wars awakens in some of us a sense of guilt, in others fatalism or nihilism, and in most of us a fear of further catastrophes. At the same time, increasing recognition of the universal importance of the events that are taking place—or failing to take place—in one country or in one continent, leads to a search for equally universal solutions.

But along with these far-reaching endeavors, the tendency to search within becomes ever more marked. After two such convulsions, there remains but a return to one's self, in order to reflect on the collective responsibility for the errors committed, on the possibility of preventing the development of impulses and passions that plunge us into hate, revenge, and war—but above all upon human limitations and possibilities, upon the sacrifices necessary to save us from the Tarpeian rock.

The devastating factor of resentment in our time, against this background, certainly inclines one to the danger of exaggeration, generalization, and encroachment upon other than psychological spheres. Examination of personal feelings, however, is bound to lead to a consideration of the psychological conditions of groups, masses, and nations; the theme only thus attains its full height and depth.

The conception of resentment [1] has been minutely examined

[1] Etymologically speaking, resentment represents the *"souvenir d'une injure avec désir de s'en venger"* (Larousse). At the same time the word means a new feeling: *"Nouveau sentiment, nouvelle sensation"* (Larousse, new edition, Vol. VII, p. 273). The fact that resentment can be doubly interpreted—as feeling and as sensation—indicates its complexity. Nietzsche (*Genealogie der Moral*, Part I) introduced the symbolic idea of resentment into the German language.

by Nietzsche and by Max Scheler and defined as a feeling rooted in some injustice and mortification experienced in the past. According to Kretschmer,[1] resentment is the complex attitude of mind of those who, in fact, have suffered injustice, or who deem themselves to have been injured. It is to see life in perspective from below; it is a constant gnawing feeling of rebellion, the many-sided attitude of the weak in relation to the powerful, of the poor toward the rich, of the sick, the degenerate, and the disintegrating toward health and youth—in a word, the mental attitude of all malcontents, who are constantly ready, in their "life-envy,"[2] to revenge themselves or to continue in their state of malicious resentment.

With resentment goes a feeling of powerlessness, but also those drives that are expressed in the endeavor to achieve revenge, respect, and might, to demand atonement from the privileged. Moreover, resentment includes secretly the tendency to expand, to collect the like-minded, to bring together all the unfortunates of life. While the feelings most akin to resentment—such as ill will, envy, bitterness, defiance, malicious joy, jealousy, and so on—are chiefly found in individuals, yet whole races and nations can be filled with the same resentment as individuals. Altogether, it may be said that resentment is a part of the normal psychological coloring of mind and spirit, and that interior and exterior conditions influence its origin as well as determine its effect on all feelings, thoughts, and actions.

The following reflections represent an attempt to understand the events of recent times in terms of psychological motives. For the explanation of conceptions and philosophical basis, we are chiefly indebted to Max Scheler.[3] We will, therefore, devote the first part of this study to the most important results of his investigations; after which we will turn to the psychology of children and youth, ending with the application of our conclusions to the socio-political uses of the present time.

[1] See his *Medical Psychology,* Fortieth edition. Leipzig: G. Thieme, 1930.
[2] See Klages' *Die Psychologischen Errungenschaften Nietzsches.* Leipzig: 1926.
[3] See his *Vom Umsturz der Werte,* Vol. I. 1919.

I

Scheler considers "ill will" to be a basic part of resentment. The most important outlet of resentment is the impulse toward revenge, which, however, is inhibited by a conviction of defeat in the retaliatory action it is likely to provoke. From the desire for revenge, through ill will, envy, and jealousy up to malice, actual resentment develops gradually through impulse and feeling, but stops short of consummation, the individual in question "making the best of things." Thus revenge leads the sooner to resentment, the less the opportunity for revenge, which is at last quite repressed. Secret pretensions, great pride in unsuitable social situations, awaken the desire for revenge, which tends to become resentment as the injury appears to be fated. (Later in this paper we shall arrive at opposite conclusions.)

Scheler considers that envy arises from the consciousness of powerlessness that follows failure to attain desired objects. Envy leads to resentment only when there are questions of values and things that cannot by their nature become possessions—*e.g.*, envy of an individual character or person, "envy of existence."

Special "situations" are full of a certain amount of "resentment danger," such as the position of a weaker—and, therefore, more envious—woman when competing with her rivals for a man's favor. Shame and pride prevent the desire for revenge for the injury, such as that inflicted by the repulse of erotic advances. "Witches," Xantippes, gossips, and such caricatures would thus prove to be forms of too prolific erotic resentment.

More far-reaching than this is the "resentment of generations," which, among other things, is caused by the falling away of the new generation from the traditions and experience of the elder. For example, the artists of the Renaissance spent the greater part of their lives in the studios of masters; works of art needed many years to be produced; several generations helped to build churches, castles, abbeys, and guildhalls. In our day, skyscrapers spring up like mushrooms; record times have obliterated the old rules. The resentment of the "old" against the "young" arises from the bitter feeling of depreciation thus engendered.

Closely related to the "resentment of generations" may be that of the pensioned, not only because of their feeling of uselessness, but because of the inadequate amounts allotted them in comparison with full wages and in view of the present devaluation of money. Their feeling is that the state is swindling them and that they are deeply injured and deprived.

In following Scheler, we find resentment among criminals, soldiers, priests, workmen—in fact, we find types of resentment in every class. Every situation in which people suffer or imagine that they suffer injustice from superiors whose status forbids appeal can lead to the formation of resentment.

The apostate is moved not so much by the conviction of a new truth as by a chain of revenge on his mental past.

What prevents, what provokes resentment? Courts of law, duels, a free press, parliamentary institutions prevent or reduce the formation of resentment, as they provide an outlet for feelings of revenge, and free them from the "mental dynamite" involved in resentment. On the other hand, resentment is provoked by dictatorships, censorship, terror, inquisition, and police rule, and can take the forms of defiance, ill will, sabotage, plotting, and underground movements, even revolution. "No literature is so full of resentment as is the modern Russian literature. The heroes of Dostoievsky, Gogol, Tolstoi breathe pure resentment. This is occasioned by the long oppression of the people by autocracy, the lack of a parliament and the censorship of the press, which all prevented the expression of the people's feelings."[1] It would be interesting to study how resentment flourishes in the Russia of to-day. The general tendency of the literature leads to no conclusions in the matter.

Like all dynamic feelings, resentment tends to expand. The boy's first disappointment results in a long period of disliking girls. The powerless defiance of a subaltern may lead to a general hatred of all authority—their uniforms, tastes, manners, and so on. Whether through aggression and open depreciation or through humility and hypocrisy, it always results in contempt of happiness, power, talent, beauty, and riches—which once were vainly desired—and therefore in contempt of the possessors. While ill will and envy are mostly

[1] Scheler, *loc. cit.*, p. 87.

passive, the desire for revenge is an active agent in the formation of resentment.

While envy infiltrates inwardly, resentment lifts the visor. Envy pales and fades. Envy is aroused by certain people or by the advantages possessed by others; the sections of the mind untouched by envy remain normal. Resentment, on the contrary, colors the whole mind, urges to battle, drives the will to conquer the injustice or the prejudice. But at the same time, the feeling of powerlessness stultifies the desire for revenge. The motives and causes of envy, jealousy, malice, and hate are mostly to be found in the personal situation and constellation of the individual, whereas resentment develops on wider planes, when we feel powerless to alter our surroundings or our lot. Thus resentment is a far more important factor in life generally than envy. (This is contrary to Scheler's ideas.)

Nietzsche considers resentment to be creative, exaggerating as it does many dangers fundamentally feared by all, such as poverty, suffering, disfigurement, sickness, and death, and conquering these evils by "sublime revenge." With this attitude of mind, one can afford to pity the beautiful, clever, strong, rich persons so lately envied. Resentment changes to kindness, benevolence, and pity. "Slaves turn to masters." The resentful person thinks himself "good" and "moral" (on the surface of his consciousness) and is freed from the painful necessity of revenge and hate (which was impossible), though deep within he may still feel the stirrings of his poisoned mind. This change, or conversion, is neither pharisaical nor false, neither calculated nor self-deceiving, but is unconscious, and therefore a change of feelings, and not of thought; it alters completely the attitude to the problems that caused resentment. (Compare the reflections that follow later in this study on social attitudes, human love, and personal resentment.)

Scheler's argument contradicting Nietzsche is of such basic importance that we may look into his theory that Christian teaching is the purest form of resentment, with reasonable hope of reaching solutions of the problems in question.

The conception of love in Christian teaching tends to eradicate and to neutralize hate and revenge, whereas the antique

conception of love was the striving to attain height, perfection, knowledge; Plato says: "Were we gods, we should not love." The antique, cosmic "agon" animates the whole sequence of dynamic spiritual units, from the "*prima materia*" to the human being, to the divine itself, which does not love, being the pole of eternal rest. On the ascent to the divine, we find all the struggles of mankind in the antique, from the gymnasium and games to the dialectics and politics of the town states, which governed Greece so powerfully and combined morality, education, philosophy, and even art into a perfect political synthesis, leading to unrivaled dignity, beauty, and antique sublimity, thus raising the conception of love to the absolute and the universal.

Christian teaching took over the antique ideals, but with an inverted sign. Nobility stooped to the base, health to sickness, riches to poverty, strength to weakness, beauty to ugliness, goodness to vice, the Messiah to the sinner, in the conviction of thus attaining perfection, of pleasing God, of gaining redemption from suffering, misery, sickness, and death and finally gaining salvation and heaven.

According to this inverted conception of love, God is no longer the universal principle, but a person, a personal God, who Himself is love and service. Love is now the best of all. Every emanation of love—friendship, love of family, of fellow men—is now a symbol and a confession of the essence of love in the person. Thus God is no longer a principle, the "agon," but the personification of love (Scheler).

Driven by the flame of a gigantic resentment, Rousseau and the Positivists, especially Comte (the inventor of the barbaric term "altruism"), degraded the original conception of Christian love to a "characterless universal love," to a sensual sympathy, emanating from social instinct that can be summarized biologically. Thus humanity took the place of God, as the "*Grand-Etre*" (Scheler).

In this way modern "philanthropy" and state social laws developed. This development was based on a "protest" against the privileged minorities, thus proving resentment against those in the possession of power. "Humanity" is a pawn in the game of hate, a catspaw for unconfessed resentment.

It can often be observed how children who have vainly tried to gain the affection of their parents and who feel themselves repulsed early develop feeling and enthusiasm for "humanity," this being a result of suppressed hate for the family surrounding them. Scheler quotes as an example the case of Prince Kropotkin, whose father replaced a beloved mother after her death with a second wife. The prince first took the part of the servants, and from this developed a negation of every Russian ideal, ending in acceptance of anarchist principles.

Another striking case is that of Dostoievsky's youth, who, from hate of his illegitimacy and from resentment against his social position, adopted revengeful social ideas, and whose foster father, on his deathbed, bade him briefly: "Whatever good you do, dear lad, do for God, not for envy."

Kant defines love as "a sensual, pathological emotion," unworthy of being placed among the incentives to moral action. No wonder, then, that the errors and tangles of a hybrid Christianity should lead to worldliness. Thus arose "Christian Socialism" and the Social Democratic Party, which strove for a compromise between utilitarianism and Christian morality. Nietzsche seizes upon this compromise as proof that the Christian ideal is the "morality of slaves," not differentiating between the genuine and the spurious ideas and movements.

Sombart [1] raises this point in his study on Battista Alberti: "It was the simple citizen who preached against the doings of the nobility, many of the preachers being themselves of noble origin; the life and manners against which they fulminated they secretly admired and longed to emulate, but for some reason were prevented from so doing. The basic factor in Alberti's works is resentment, a positively ludicrous and childish hate of the 'Signori' he was debarred from joining. Every tirade ends on the same note—the pharisaical praise of his own citizen class. This resentment has remained for all times the strongest prop of 'bourgeois' morality."

Scheler considers the modern teaching of social equality to be explained by the resentment of the unfortunate. Behind

[1] See his *Der Bourgeois Minchen* (Leipzig, 1913), Part III, Chapter 27, pp. 439–40.

the apparent harmlessness of the demand for equality lurks the desire to drag down the more fortunate and the richer to the plane of the less well-situated. Demand for equality is always a "bear speculation." But the resentful individual is a weakling unable to carry out his convictions, as, on the contrary, can a man aiming at good, who can feel and act unsupported. A weakling strives to generalize. He is unable to realize his desires and wants to raise an edifice without foundations by building on his equally incapable fellow weaklings. This is similar to the childish trick of trying to shelve responsibility by blaming fellow sinners: "It wasn't me. He did it, too!"

In this way the herds of the resentful cling together and their demands replace "objective good." The morality of slaves becomes mob morality and develops by degrees into biological morality. According to Kant, objective good is replaced by "a general law of the human will," and thus "class morality" creeps into modern ethics.

Here we are met by the fact that only a small party in one generation is interested in certain problems while the majority condemns such interest as undesirable and even harmful, being itself of the accused class. But the inability of the man in the street to grasp higher mathematics or the atomic theory does not do away with these facts, and it is equally unfeasible to abolish abstract and spiritual values because a majority of people take no interest in them. This enforced renunciation, however, encourages resentment among whole classes and wakens the unconfessed desire to do away with "cultured people" in the "classless State of the Future."

An ascetic trait has crept into the modern conception of morality; useful work is better than idle enjoyment, more and more work, feverish production. This idea has helped to develop modern capitalism, which knows how to utilize it. This also applies to state "planning"—the increased production of pleasant and useful things, the enjoyment of which is condemned by the eager producers themselves. This modern asceticism leads *ad absurdum,* to the ideal of maximum production and minimum enjoyment of useful and agreeable things.

Modern morality has practically become "class morality,"

a contract imposed on the individual by the masses. Respect and responsibility are replaced by despotism and obedience. The majority principle becomes the will of the state, to the cost of the most noble, the "elite." That is the victory of the unfortunates in life, the victory of resentment. The anthropomorphic conception regards all organs as equal parts of the whole. Kant considers that the various organs should be taken as comprising in themselves the life of the whole, the whole being dependent on the parts. Resentment, on the contrary, seeks in all life analogies with dead material: the photographer's lens becomes an analogy of the eye; life becomes an episode in a mechanical world process, an adaptation to a fixed universe. Utility ranks above culture in this anthropomorphic world. This reversal of values is the cheap victory of the unfortunate, who thus temporarily indulge their resentment at the cost of mankind.

Up to the present time, we have not been able to grasp the results of this "tool civilization," because it absorbs a general resentment, which rejoices in the depreciation of former values, when not indifferent to them.

This development is not confined to any single political structure; it affects the programs of Capitalism, Socialism, Communism, and National Socialism, resentment being more or less apparent in them all.

The fact that only a few are interested in the central problem is very noticeable among the children and youth of the post-war period. The disadvantages arising from impaired health and strength, from loss of social freedom, money, and position, combined with hypersensitiveness, tend to create resentment. Added to these factors are the effects of the struggle for a living, the distortion of justice in the mind, of tradition and morality also, causing the world of the "grown-ups" to appear in a very questionable light. The problem before a child is the problem of growing up, of becoming a man; the problem of the post-war child is the lack of example, in cellars, in cold and in hunger, in a world of resentment, when it expected a paradise, innocently lost or now indignantly denied as a fiction.

To summarize, the following four conditions can be observed in any resentment:

1. *Injustice suffered*—the experience of humiliation, whether real or fancied, whether inflicted by those around or by fate. The point is that the person in question always considers himself the injured, innocent party.

2. *Powerlessness*—the victim recognizes his inability to reinstate himself, realizes that his rebellion is in vain.

3. *Refusal* to acknowledge inferiority.

4. *Drives* resulting from the thwarted desire to inflict revenge, to return the insult, the wish to do away with the cause of the injury. The feeling of powerlessness, the consciousness of the impossibility of altering conditions, along with these drives, constitute a state of mind that permanently affects all feeling, thought, and action.

The mental effects of resentment may be classified as follows:

1. *Depreciation* of the superior position, advantages, and privileges considered unjustly enjoyed by others.

2. *Revaluation* of the subjective situation, exalting the unfortunate.

3. *Influence upon the mind:* Resentment colors the entire mentality.

4. *Expansion:* As a consequence of the impossibility of personal revenge, an impulse toward expansion develops. The individual who knows himself to be powerless presupposes that power is to be found in numbers and in fellow sufferers; he seeks out his like, who, in certain extreme cases, become his followers. Thus we are led from individual resentment to

5. *The repercussions of resentment:* The fact that we perceive the feelings of a person and can respond to them presupposes effective repercussions of these feelings in ourselves. We call this mental quality echothymia. For example, sympathy can awaken sympathy, which may prove temporary or permanent in the mind that offers latent possibility. This sympathy develops into friendship or love, as antipathy develops into enmity or hate.

While envy, jealousy, and so on, are confined to an individual situation and experience, there are influences that tend to expansion, because the repercussions are latent and normal in every one. Hate or panic, for instance, can spread like wildfire; aggressiveness, fear, and the instinct to flee form

parts of the normal psyche and free latent mechanisms of self-protection. These reactions are apt to disappear once their cause is removed, except when certain natures retain what was specially latent in them and thus remain permanently affected.

It depends on the latent readiness in the individual whether he repudiates, let us say, the resentment of a political agitator or responds with an exaggeration of his own resentments.

Events in our time have proved, by world wars and revolutions, that individual resentment is capable of awakening colossal echoes, given a certain readiness in classes, groups, castes, or nations. The soci-political importance is almost incalculable, as in all cases of mass-psychological phenomena.

After this synopsis of the effects of resentment, let us pass to a summary of the forms of individual resentment.

II

The happy family stands admiring the newborn miracle.

The child is cared for and guarded; his first wants are pacified, his wishes fulfilled, his desire for pleasure and love are satisfied. The child at first feels one with his world; he is absolutely content. He is gently trained to cleanliness, scolded or punished but lightly. Screams and kicks are at first mere reflex action. We are moved because of their helplessness and naturalness; they are as yet impersonal, truly innocent. The proof of this may be seen in the reaction of the surrounding adults. No one is angry; if the child's cries annoy the father, it is to the mother that he complains.

At a certain time the child becomes conscious of his individuality. His own memory develops, adds to instinct. The boundaries between his ego and the surrounding world become defined. His own feelings, experiences, and thoughts help him to an opinion. Thus the child becomes a person, an individual, and discovers means to gratify his desires, to convert means into actions; his will develops. He discovers the world as a mighty reality to be lived, feared, and sought.

His father is normally the incarnation of this threatening, yet protecting power; what he says, the child believes, admires what he does; he incorporates justice, power, perfec-

tion, the absolute. The child identifies himself with this ideal, is furious should it be threatened or doubted.

Whether trained or spoilt, every child's "biological narcissicism" is accentuated by the care bestowed upon him, which tends to develop his egocentric tendencies. By the time he is one year old, at an age when thought and judgment are still vague, the child commands all the feelings it needs for play-acting, gaining advantages, and often tyrannizing over his fellows. Especially prone to this development is the eldest or the only child, the child of elderly parents.

But sooner or later every child suffers a first wound to his sensitive pride, the first narcissan wound, for the feeble, awakening ego cannot as yet struggle with reality. At this stage, the fraction of reality with which the child comes in contact is represented by his family, his social class, or his school. In this section of the world he develops his first resentment.

If the child feels that he has suffered injustice and at the same time realizes his impotence to alter conditions, the basis is given for an increase in dynamics. His impotence leads to sulkiness, to repression, to the storing up of grudges, and the desire for revenge, all of which are the result of the wound to his pride.

A wounded ego responds in various ways—by defiance and rebellion, but also by the excision of that part of reality that has offended it. Psychologically, it is immaterial whether the child carries out this excision by "Christian behavior" and abasement, by nonresistance and nonviolence (Gandhi), or by magnifying himself at the cost of the offending piece of reality. It remains psychologically immaterial whether the resentful child accuses (projection) or encloses (introjection) the object of offense in his ego, in his aim for revenge. A serious factor is the "fear of guilt," which comes from the desire to annihilate the offender. Many a neurosis and phobia can be understood from this perspective; if not cured, the wounded ego withdraws from the "horrid world" which it cannot abolish. But just this partial loss of reality creates fear—bare, primitive fear. The child feels cast out of his protecting Paradise by his own fault and fears that he must pay all his life for his misdeeds.

Who most cause resentment in children? The answer is, they who themselves are resentful. They are the first offenders, because they mostly vent their impotence, their grudges, their desire for revenge, with impunity on a child. How many fathers have revenged a marriage failure on a child! This theme has been almost classically treated in Jules Renard's book, *Poil de Carotte,* among many other works on the subject.

Years of injustice and wounds to dignity and pride suffered by a child affect the soul more than even a terrible, but single experience. A resentful child whose tendency is not recognized is apt to be confirmed in resentment of mind by a disadvantageous position at home or at school, and will hardly free himself from this chronic defiance even after coming to maturity. Special and typical situations frequently breed resentment in childhood, such as the position of stepchildren, of illegitimate or of adopted children. There are countless cases of resentful children, however, in happy homes, in which circumstances force the parents to part.

Every child is a narcissan, but a wounded ego seeks compensation, often to the highest degree, and the child's impotence to gain this compensation leads to bitterness and resentment, to hate, rebellion, defiance, obstinacy, jealousy, malice, ill will, enmity, and whatever else may be detected in the spectral analysis of warped characters. We cannot "reëducate" such qualities until we discover their complex origins. It would be wrong to trace every unsocial and antisocial attitude to simple resentment, as it would be wrong to overlook its deep, tangled, and prevalent existence.

A resentful child becomes a resentful scholar. Take, for instance, a pupil who has once been unjustly punished, put back, and accounted inferior. He will neglect his work and even defy his master, in the hope of injuring him. Then we have the resentment of difficult pupils against "model children," ambitious or hypocritical fellow scholars; the resentment of the less talented, who know that they will be surpassed by the more brilliant.

Resentment is seldom absent in the suicides of scholars, this being the expression of the mentally weak, whether the weakness be real or imaginary—of those who are so hyper-

sensitive to injury of any kind that they feel life to be insupportable. Letters of farewell left by suicides often show whether the motive was melancholia or whether resentment played a part. In the latter case, lengthy justification or accusations are usual.

In this study we are passing over the many neurotic forms that resentment may induce, as we intend to treat them in a separate article, which will take up also the mental disorders that may ensue. We quote here, however, one medical case, supplied by the analyst L. Szondi, to show how early resentment can influence the love life of young people.

He: A forty-four-year-old journalist and designer, whom we will call XV, frenziedly attached to his father. As far as he can remember, his father had always suffered from heart trouble, and he had often assisted him to inject remedies, when he himself was a boy of twelve or thirteen. His father was a doctor, unhappily married, and XV tells of harrowing scenes, when his mother turned away from her husband in his heart attacks and left the boy alone to help. His father died when the boy was fifteen. Kneeling by the deathbed, the boy swore to revenge his father's death on his mother. His resentment never left him; he identified himself with his father and this influenced his whole life, his relations with people, and specially his love affairs. He had no respect for women and treated them sadistically, until he met a woman who was able to stem this cruelty and to turn it against himself.

She: It appears that this woman had been through similar experiences and, like XV, was full of resentment. Her father, a manufacturing chemist, had consorted with prostitutes all his life and infected his wife with gonorrhea, which resulted in severe peritonitis. Her sixteen-year-old daughter had to watch her mother's struggle with death for many weeks and during this period, her attitude toward men determined itself. After her mother's difficult recovery, she went abroad and lived a sexually loose life, the evident motive for which was to take revenge on men—in fact, resentment, as in the case of XV. When the two resentful, revengeful people met, they would seem to have been well matched—he with the memory of his father, she remembering her suffering mother.

The Marriage: There was little love lost between them at first. It seemed to be a sado-masochistic union, in which the man degraded the woman and wounded her self-esteem to the degree of causing her to leave him. The husband then found that he could not live without her, becoming so melancholy that he could not work and several times attempted suicide. But whenever they resumed married life, he returned to his sadistic behavior, inspired by the resentment that dominated him. Again the wife left him, again he fell into masochistic depression. In this condition he came to us and underwent psychoanalysis, which showed this: In his youth the man had longed to slay his mother or at least to inflict revenge upon her; the woman had felt the same way about her father. Because of their identification with the injured parents, resentment had influenced the whole lives of these two people.

The success of their treatment leads to this conclusion: Had these two persons not had cause for resentment in their youth, they would most probably have remained free from it. They were united by their common experiences and frame of mind, rather than by fate. This example illustrates the importance of prophylaxis when resentment is in question, and especially the importance of recognizing it early. It is surprising that these complex entanglements of feeling should not engage more interest than they do.

Boys are most inclined to resentment during the years of puberty. During this period they suffer from hypersensitiveness; they are not taken seriously, are treated as boys, when they feel that they are really grown-up men. It is the time when many failures and disappointments occur, caused by the discrepancy between dreams and actuality. These losses of prestige, these humiliations, with their wounds to pride and vanity, may lead to resentments that influence whole lives.

It is in this period that the first disappointment in love may occur, combined perhaps with sisterly, and even motherly, teasing. As a result the boy may become for many years one of those pitiable woman-haters, such as we find turning to Baudelaire, Schopenhauer, Nietzsche, Weininger, and others, for comfort and aid in their resentment against the other sex.

Tremendous resentment, again, is felt by young people against the closed ranks of the older generation who occupy good positions and look upon the young as nuisances and future rivals. Frequently young people are obliged to take up work, or a profession, at times when they are painfully resentful, and they carry this feeling on into an occupation that they would not have chosen for themselves.

Sex resentment develops prolifically through the woes of childhood and puberty. It creeps into the feelings of those who think themselves hurt, abased, betrayed, and at a disadvantage, with no hope of rehabilitation or revenge. They try to assert and justify themselves by depreciating their rivals, by lies, intrigues, and slander. Making mischief among their relatives and even their own friends satisfies the instincts of the resentful. They search for support, because the resentful are weak; they seek approbation, because they feel uncertain of themselves.

The fact that women, both married and single, often develop resentment against a once-beloved man is to be explained

by their specific disposition, and also as a consequence of their dependent families and their social position. If, however, a woman succeeds in reversing this situation, we often observe that the man is seized by resentment in the same way.

Another type of sex resentment is to be found in the rather more tragic than comic figure of the mother-in-law, "the mother of the son, whose relation to the beloved child is complicated through diversity of sex. She is called upon to bear a situation that the devil might have invented to test a hero; she sees the being she has loved and cared for since his birth suddenly turn to another, one of her own sex who has done nothing for the beloved one so far, and yet feels entitled to everything. She is called upon to bear this gladly, to rejoice and to congratulate."[1]

Resentment in cripples, which is treated of in the works of various writers, is of a different quality from any that we have yet considered. Cripples may develop resentment, not only because of their deformities, but because of a certain predisposition. Mutilation or deformity may indeed lead to depressions and complexities, but also to adaptation and habit, sometimes even to compensation. Stammerers, humpbacks, sufferers from the effects of infantile paralysis, the deaf and dumb, the blind, have become famous statesmen and authors, remarkably generous and free from resentment! It is also noticeable that those who suffer from the inherited results of alcohol, syphilis, or tuberculosis do not develop specific resentment and, in any case, do not show a higher proportion of resentful people than do the organically sound. An exception may be found among war victims, those injured or crippled in battle, who are very naturally embittered. This bitterness closely approaches resentment and leads to the formation of isolated clubs. These exceptional cripples serve to prove the rule.

There are, again, the resentful critics. These are those grumblers and would-be critics who indeed have artistic feeling, but also sufficient self-knowledge to refrain from any artistic performance, though they do not acknowledge their inferiority. Resentment engenders the desire to show up and to accentuate the least deficiency in the work of others,

[1] Scheler, *loc. cit.*, p. 80.

an unconscious act of revenge. Self-justification is sought by depreciation of others. The last characteristic of resentment—the urge to attain leadership by any means—is specially noticeable in the resentful critic, who with one unexpected blow at the artist can shatter work that he himself has striven, for years perhaps, to carry out. It is easy to see the combination of envy, jealousy, revenge, and pettiness, if less easy to follow their amalgamation with the more complex quality of resentment.

Are any professions safe from resentment? It may be found in every profession and trade. The unskilled workman is apt to resent the craftsman; the ignorant resents the educated; the peasant resents the townsman; and so on.

The resemblance between the profession of officers in the services and that of teachers draws our attention to that resentment which, instead of "going up" as usually, "goes down." Officers and masters who house resentment frequently vent this resentment on pupils or recruits, in a wellnigh sadistic fashion, and the victims are unable to retaliate, being in the disadvantageous position occupied by children in relation to parents or guardians.

We can only wonder how much resentment is thus bred by resentment. Many memoirs, tales, and literary works would point to a considerable part played by educators in the formation of resentment.

These examples are intended to show that resentment may form without a specific predisposition, given certain personal or social circumstances. It is immaterial whether the case is that of a soldier developing resentment against his officers, against the army, against his whole country, or whether it is a little clerk or an ambitious plodder in a high position. The point is what the individual thinks of his position and of the position that he considers he ought to occupy. Even more important is his reaction to fate—a fate that has placed him where he feels he does not belong. Most important of all is his relation to those around him, for this determines his future. The resentful man is doomed in these circumstances, not by "fate" in the true sense of the word, but by the repercussions of his resentment in his personal life, by conditions in his family, class, and social situations, which although

facts, are not "fate" and are not unchangeable, are not bound to the laws of heredity or written in the stars.

This explains the presence of resentment in every class of people and society, given the same conditions.

III

In the "battle of classes," in the attitude of the workman and the employed, we frequently encounter the resentment of the less well-to-do, of the "lower classes," against the wealthier, the more privileged, and the more powerful, which can develop into a mass psychosis.

The same factors and conditions that breed resentment in the individual apply to classes and groups, with one difference—that is the fact that sharing resentment with many others tends to lighten the individual's burden and may, indeed, evoke pride in it. We observe this very acutely in racial resentment, which easily becomes racial pride.

If we consider the great humiliation, contempt, and oppression endured by Negroes, we can only marvel that their resentment against the white races is not greater than it is.

Jewish resentment must be treated as an exception, for it has been a problem for several thousand years and cannot be defined in simple terms. It probably will long continue to cast discredit on Western civilization and culture.

It would be beyond the compass of this study to treat Jewish resentment here; it involves so much history, religious history, race psychology, and other factors. We must confine ourselves to a few reflections on the subject. As a "class battle" engenders the resentment of the great majority of the less well-off against the minority that make up the privileged classes, so we see a vast majority in almost every Western race resenting a minority—the Jews, who usually form but a small percentage of the population. Certainly there have been Jews who have displayed resentment after suffering humiliation and insults to a very great degree, but, on the whole, Jews display far less resentment than could be expected of them and far less than Gentiles show to Jews. In his dealings with the colored man, the white man shows contempt, but no resentment, for his superiority is assured; with the Jew, this is not the case.

It is a curious fact that almost all nations and parties alternately form unions and quarrel, hate and love; that Jesuits, Huguenots, and Crusaders fought in resentment, often only to be exterminated by their opponents' resentment. In our own day the Armenian nation was driven into the desert by the Turks and perished, and the last world war caused many minorities to be driven from their homes in the most cold-blooded manner and regardless of the most elementary rights of man. Such atrocities are soon forgotten, whereas the resentment incorporated in anti-Semitism has remained unchanged for over 2,000 years, despite Christian teaching, despite the transient shudder of disgust at the atrocities perpetrated by the German National Socialists; with the result that the Jew remains the scapegoat and the Gentile reproaches him for it, while at the same time punishing him for it.

When the National Socialists had rendered anti-Semitism idle by extermination of the Jews, they fell upon fresh victims in their overweening resentment. New enemies of the state, "dangerous people," and traitors, all served the spite of their insatiable resentment. The fact that millions of refugees (so-called D.P.'s), bombed-out and homeless people, deportees, war orphans, and cripples are suffering to-day as victims of resentment, and will long continue to suffer, opens up immeasurable sources of fresh resentment and tends to prove that resentment is universal, and that its early diagnosis is of imperative importance, especially in children.

Political defeats, economic weakness, and social evils have at least aroused a wish to better matters, to seek some way out of the troubles that oppress all classes.

In olden times the individual could liberate his resentment in duels, groups could give expression to theirs in local fighting, and democracy offered every one a real chance to show his mettle. Nowadays concentration and nationalization of production tend to crush the individual, to do away with his sense of responsibility, to impress him with his powerlessness. This results in some cases in resignation, indifference, discouragement, absorption in sport and amusement; in other cases it develops revolt, defiance, and resentment. This resentment is all the more deeply felt in that it was not necessary, it could have been prevented.

The salient figure among types of political resentment is the furious, enraged, and shouting demagogue, the agitator who hides his revengeful and usurping motives behind a screen of nobility.

No political figure in our time furnishes a better subject than Hitler for the purpose of examining to what degree the feelings and thoughts of the demagogue are dominated by resentment. Many psychologists and psychiatrists have attempted to explain Hitler's rise, successes, and catastrophes by his probably diseased mentality. But plain diagnoses, or labels, such as psychopathy, hysteria, paranoia, and so on, explain Hitler's career no more than "madness" explains Van Gogh, Maupassant, Strindberg, and Schumann, or "syphilis," Nietzsche or Mussolini. The psychiatrist Wilmans indeed confirmed the fact that, in the first world war, when Hitler suffered from hysterical blindness, he was sexually apathetic, perhaps latently homosexual, and that his distrust and suspicion verged on persecution mania. His consequent rôle of playing the martyr, to justify his demands, his threats, and finally his attacks, reminds one of paranoics, who usually end in mental hospitals or in suicide, after endeavoring to destroy as much as possible of their surroundings.

Although Hitler tried to envelop his youth and origins in secrecy, enough details of this period are known, together with his own sayings and actions, to betray constant resentment to a degree that constitutes him the paradigm of political resenters.

Hitler's political talent for playing off one party against another was, in some degree, due to his ability to stir up and make use of resentment. He set the shopkeepers against the chain stores, the out-of-work against employers and the government, little factory owners against industrial magnates, which last-named class supported him financially to an enormous extent, for fear of the Communists. Thus he encouraged any opposition that tended to strengthen his own position. He even did nothing to pacify the dissensions in his own party, the disputes of the S.S. and the S.A. with the army; on the contrary, he acted on the principle of "*divide et impera*" everywhere and always. Besides this, he knew how to wait till the ripe fruit fell into his hands, at least during the first

few years, until his European victories turned his head and fostered his belief in his infallibility.

Whether Hitler acted consciously or instinctively is immaterial, whether he carried out his plans with forethought or with intuition. Our interest lies in the appeal to secret, slumbering, collective propensities and feelings, chiefly resentment, which were roused and exaggerated to mass psychologies because their "creator" was not only not ashamed of them, but boasted of them and accounted them the sources of his power and victories. The justification of his boundless contempt both for enemies and for friends, his cynical immorality, led him to reverse all existing values. This trick, at first successful, and developed from resentment, would seem to explain Hitler's psychology more accurately than the theory that he was influenced by "biological views."

We have studied the resentment engendered by normal psychological motives and caused by given situations of the resentful subject. Logically speaking, it ought to disappear once the cause is removed. But in dealing with Hitler and his like, we have to do with such deep infiltration that there is no possibility of disappearance. On the contrary, resentment is stimulated by success to a degree of raving confusion. This limitless expansion is a tendency we meet with in paranoics, fanatics, and certain epileptics. It explains why Hitler constantly extended his conquests, executed even his friends, became ever more suspicious, entirely lost the faculty of correctly weighing facts and events, and misjudged first the position abroad and then that in Germany. He isolated himself from every one and ended in suicide, as a lonely madman, because he was not able to control the causes of his resentment, to crush the whole world, including the nation that had permitted his resentment to rage in the hope of revenging their own resentment through Hitler.

It is not to be denied that we have been dealing with the abnormal, but Hitler's almost fabulous career cannot be explained simply on pathologic grounds, nor could such an explanation help to solve the problems remaining after his suicide. We have already observed that madness did not tend to improve the work of many a recognized genius. That Hitler was no genius and that his work was purely destructive

is of no importance to psychological research. Of paramount importance is the fact that his personal resentment reverberated amongst a nation of eighty million souls till they absorbed it and forced the rest of the world to bloody resistance. The war is apparently over. In fact the war is going on, bitterly, if underground. The resentment left by the war has not been abolished during the post-war period.

We have tried to illustrate the importance of psychological motives by utilizing the most tragic of examples and to show how such motives lead to world-wide catastrophes. The collapse of Hitler's Germany has not abolished social, economic, or political resentment. In accordance with the psychologic law that, through paradox, the victor often inherits the mentality of the victim, resentment is flourishing more than ever in the life of every nation, class, and race. Here begins our work. How can we teachers, doctors, educators of all categories, all who carry responsibility, best protect youth from the formation and the misuse of fresh resentments? Here we have one of the least noticeable, but most deeply rooted difficulties in the path of reëducation, and its timely recognition and healing is a *sine qua non* in the process of spiritual regeneration.

We may consider it proved that the majority of people think, feel, and act under the sign of resentment. Therefore, the possibility of the formation of resentment lies in all normal individuals. Most resentments begin in youth, but the results appear in the adult, who passes down resentment to children, thus forming a vicious circle from one generation to another.

A policy free from resentment demands politicians themselves free from it. This, again, requires an education free from resentment, and this will be difficult as long as adults vent their resentment on youth and so generate resentment in the young. The breaking-up of this vicious circle is one of the most vital importance in the tasks of education and reëducation.

The therapy of this festering disease in our time lies in the eternal values of our human culture. Not expansion, not the satisfaction of material needs, but the inner trend, the recog-

nition of true cultural values, can lead us from the devilish influence of all resentments to the sense of personal responsibility, to true humanism. We must not expect too much, for the entire bitterness of human nature resists dissolution. That great connoisseur of mankind, Balzac, points out our limitations when he says: "Human nature tends to destroy what it cannot itself possess, to deny what it does not understand, to degrade what it envies."

Perhaps the final solution in the therapy of resentment is to be found in the response of the individual to the sacrifices demanded of him by life. Thus the most sublime task of every one connected with the guidance and protection of children would seem to be the strengthening of them to meet these sacrifices.

VOCATIONAL REHABILITATION OF THE PSYCHIATRICALLY DISABLED *

THOMAS A. C. RENNIE, M.D.
Associate Professor of Psychiatry, Cornell University Medical College

TEMPLE BURLING, M.D.
Field Director, Division on Rehabilitation, The National Committee for Mental Hygiene

LUTHER E. WOODWARD, PH.D.
Field Consultant, Disivion on Rehabilitation, The National Committee for Mental Hygiene

VOCATIONAL rehabilitation of the psychiatrically handicapped has been long neglected. Too often after discharge from a psychiatric hospital have patients been left to their own initiative in finding work that is satisfying. Reintegration back into the community has often been haphazard. The psychiatrist is too often satisfied with a study of the personal dynamics and analysis and removal of symptoms, to the neglect of the profound social and occupational factors involved. It is to be emphasized that the hospital belongs to the community, and that treatment should see the patient through to maximum social reintegration into the community. Job finding, job placement, and follow-up are important as the final stages in the process.

The Borden-LaFollette Amendment to the Federal Rehabilitation Law of July 6, 1943, made available to the psychiatrically handicapped the resources of federal and state rehabilitation divisions. This means that every psychiatrically disabled patient can get help in job finding, vocational guidance, vocational training, and occupational counseling, whether he be a veteran or a civilian. If accepted for training, his tuition will be paid, books and other study material will be purchased for him, and maintenance and transportation will be provided if needed.

Few psychiatrists know of this service, and almost none utilize it. Two years after the program had started, only one-

* Presented at the One Hundred and Fourth Annual Meeting of the American Psychiatric Association, Washington, D. C., May 20, 1948.

half of 1 per cent of all cases referred to state bureaus came from state hospitals. The Federal Vocational Rehabilitation Bureau reports that in the year ending June, 1947, only 2,546 psychiatrically disabled patients in this entire country were given rehabilitation service. Only five states gave service to more than 100 cases: California, 372; Michigan, 359, New York, 172; Connecticut, 162; and Pennsylvania, 103. Only six states gave service to more than 10 patients who had previously suffered a psychiatric illness: California, 53; Michigan, 31; Texas, 20; New York, 16; District of Columbia, 16; Montana, 14. Nineteen states have not given service to a single post-psychotic patient.

Is there a need for such service? Do state hospitals recognize the need and do anything about it? Is vocational rehabilitation feasible and possible? What is the actual process? How can the process be best integrated with hospital care? What organizational changes are needed? What results can be anticipated? These are questions that the Division of Rehabilitation of The National Committee for Mental Hygiene undertook to answer in a study undertaken some two years ago in four state hospitals in three states—New York, Connecticut, and Michigan. It is too early to answer all of these questions. This is a preliminary report only, and later studies will follow. The present paper concerns only the psychotic group.

In an attempt to evaluate vocational needs, many hundreds of convalescent and discharged patients' records were studied. Immediately it became evident that many patients leave hospitals to return to former established jobs. Housewives have their assured place. Many of the aged and physically infirm are unemployable.

The need, however, is a real one for patients in the younger age brackets, for those in whom a poor vocational adjustment contributed to their illness, for those whose personalities are appreciably altered by their psychosis, for those who have been out of occupation and hospitalized for many years, for those middle-aged married women who prefer work as added zest to their household responsibilities, and for those women who have lost the support of their husbands by death or divorce.

In Brooklyn State Hospital an employment inquiry was

sent to approximately 600 recently discharged patients who had been out of the hospital for from three to fifteen months. Replies were received from 223. Of these, 107 reported that they were satisfied with the work they were doing. Of the remaining potentially employable group, 19 per cent were not working and wanted some kind of rehabilitation service; 4 per cent were working, but asked for help. In all, 23 per cent of the potentially employable indicated some need for rehabilitation services. Approximately 80 per cent of those requesting help were diagnosed as schizophrenic.

A second effort to determine the need was made by study, through records and personal interviews, of 747 patients on convalescent status at the Brooklyn State Hospital. At the time of the initial study, 249, or 33⅓ per cent, of these, exclusive of housewives, were satisfactorily employed. One hundred and sixty-nine, or 22.6 per cent, were considered by the social-work staff to have an uncertain vocational future. Six months later a team consisting of two staff members of The National Committee for Mental Hygiene, the social-work supervisor of the hospital, who has had much experience in employment problems, and the counselor of the Vocational Rehabilitation Bureau, reëvaluated this latter group. During the six month period, 42 more patients had achieved satisfactory work status, 20 were considered to be marginal workers and not advisable for rehabilitation, 22 had been referred to the Rehabilitation Bureau, and 55 more showed need for such service, some of them with continuing psychotherapy and others requiring only training or placement help. Forty-four had returned to the hospital, and 30 more were considered too ill to work, although living at home. Four refused help of any kind and two were in the hands of the law. In all 10.3 per cent of the total 747 were then receiving or needed rehabilitation service, and an additional 5 per cent might need it later, after further recovery.

At the Norwich State Hospital, Connecticut, we studied a series of 222 patients who had been transferred to other hospitals or placed on convalescent status. Of these, 76 (34.2 per cent) were working satisfactorily; 23 (10.3 per cent) were found to be in need of vocational rehabilitation. Thus we can answer our first question in the affirmative. There are a

sufficient number of cases in psychiatric hospitals in need of vocational help to warrant the inclusion of such services, and the development of vocational programs as a part of psychiatric treatment. This need is little recognized by size and number. In one state hospital, a study of the records of 167 patients who were on convalescent care or who had been discharged to the community revealed that in only 88 cases (approximately half) did the records give any indication of the vocational background or future plans of the patient. In 79 cases, there was no reference, direct or indirect, to the vocational future of the patient. In 25, it was not possible from the record even to determine whether or not the patient was sufficiently recovered to be employable. Psychiatrists must reach the point where the future vocational needs of every patient is considered and recorded.

Finding the cases with a vocational need should not be a difficult task. It is logically a part of the psychotherapeutic process and is, therefore, primarily the responsibility of the psychiatrist. Where the case load is small, this process would undoubtedly occur spontaneously. In large hospitals, particularly state hospitals, this special need of the patient may be lost in the administrative complexities. The best results will be obtained when the entire hospital staff are alert to the probable need for vocational rehabilitation. The need should emerge at the time of the taking of the psychiatric history, whether that is done by the psychiatrist or by the social worker, by the inclusion of systematic questions in the history. At some point during treatment, aptitude testing and vocational-guidance services may be needed. It should logically begin while the patient is still in the hospital. Where psychiatrists are overburdened, the social worker must take over the responsibility.

The participation of the vocational counselor at every staff conference would be particularly valuable. In the beginning at least, staff members are likely to need some orientation to prepare them for the aims and possibilities of vocational programs. As a result of experience in several state hospitals, the following recommendations for planning for vocational rehabilitation are offered:

Planning for vocational rehabilitation should begin at the

time of the patient's admission to the hospital, with consideration of his previous work history, his vocational interests, aversions, potential satisfactions, and preferences. The determination of work interest and employment satisfactions should occupy increasing attention in psychiatric interviews, once the patient is moving toward recovery and parole. At the time of consideration of parole, it would be well to check with the psychiatrist, the social worker, or the vocational counselor, to make sure that the patient has good work prospects, or that plans are made for vocational guidance, training, and placement as indicated. Consideration of the vocational needs and adjustment should be an essential part of the services given by the hospital staff during the convalescent period. If the need for employment is indicated, reference of the case to the rehabilitation or employment services should be effected.

Rehabilitation is successful only when there is full participation by the patient in the entire process. This means that until rehabilitation services are more widely known and accepted among patients, efforts must be made to acquaint them with these services. In the beginning this will have to be done with individual patients, and should be the primary responsibility of the physician. Experience indicates that patients are very apt to reject the rehabilitation service the first time they hear about it. But once the program gets established, knowledge of the services of the rehabilitation division become spread throughout the hospital. Group methods can later be utilized in this educational process.

References to the agency are best made through personal consultation or conferences with the rehabilitation agency or counselor. This is particularly important in the earlier stages of working out coöperative relations. Whether actual reference is made by a letter or by an inter-staff conference, it is important that the patient become acquainted with the rehabilitation counselor before leaving the hospital. If the contact between the patient and the counselor is postponed until after the patient leaves the hospital, there is always a loss of rapport which may be irreparable.

What the rehabilitation agency most needs is a clear picture of the kind of person the patient is, with special reference to

his vocational preferences and needs. It needs to know something about the personality of the individual, as well as the important family relationships that subject the patient to pressures and tensions which may complicate the rehabilitation program. It needs to know whether the patient has fully recovered or whether further psychotherapy is needed, and if so, whether the hospital will give this service or whether it should be obtained elsewhere. The psychiatrist cannot be expected to give specific advice about job placement. He is not in a position usually to know the actual detailed work conditions in various occupations and industries. This is the rôle of the counselor. He cannot serve this rôle well without consultation with the psychiatrist.

Rehabilitation usually comprises five interrelated services:

1. Vocational counseling, including evaluation of liabilities and interests. In the process psychological testing is utilized to determine the patient's abilities, disabilities, and special interests.
2. A. Helping in the choice of vocational goal and knowledge of job requirements and opportunities.

   B. Vocational training through enrolling the patient in a trade or professional school, or by arranging for on-the-job training.
3. Physical restoration. This includes emotional restoration, and the state bureau is empowered to pay for treatment of psychiatric disabilities, usually of chronic (but not of acute) conditions that can be demonstrably shown to constitute an occupational handicap.
4. Job finding and placement. The discovery and development of jobs that are within the abilities of handicapped people calls for the specialized knowledge of the rehabilitation counselor.
5. Personal counseling throughout the entire period of rehabilitation, and follow-up of the individual until his occupational adjustment is complete.

It has been determined that the largest number of patients who will need and profit by rehabilitation services are young people (largely schizophrenics) who have had little or no previous work history. They need plenty of time to find their

goals. They need help in adjusting to themselves. They need accurate information about the satisfactions and dissatisfactions to be derived from particular kinds of work. They are apt to be unrealistic, and their first plans are often impracticable. The counselor needs unending patience to help the patient to a final plan that is his own plan and not the plan of the counselor. In Michigan it has been regularly found that the counselor's process takes two and a half times as long for the emotionally handicapped as for the physically handicapped.

If achievement of the goal involves training, it becomes necessary to orient and educate teachers. They usually have not only little understanding of, but active aversion to, the needs of the mentally handicapped. No generalizations can be made regarding the kinds of work that can be done by persons of any given psychiatric diagnosis, except that the job must recognize intellectual limitations. There are wide differences of vocational interests and abilities within all clinical groups. The determining factor in successful work placement is the individual combination of assets, skills, limitations, interests, and aversions.

The function of the counselor is to help the patient to a work goal in which his maximal potential is approximated in terms of such factors as intellectual capacities, skills, and aptitudes, vocational interest or preference, and physical condition. To do this, the particular work setting must be thoroughly understood and related to the patient's personality. It requires an analysis of the working situation, which includes attention to the physical set-up, the relationship with staff and supervisors, hours of employment, degree of responsibility, and the nature and level of work and production requirements. Matching a patient's needs to a work goal is a professional undertaking. The counselor must know the patient's needs and the job satisfactions, the need for adequate earnings, steady employment, and advancement opportunities. Many hours of interviews may be necessary before this professional case-work relationship is satisfactorily resolved.

The choice of school or training agency is important, and must be determined by the individual needs of the patient. The final work placement often requires interpretation to

employers. There may be a marked unwillingness to consider for employment persons who have had an emotional or a mental illness. Fortunately, however, there are a growing number of industrial organizations that are willing to experiment in the employment of these individuals. The employment counselor is in the best position to have established sound relationships with employers in the community. The task would not be complete without follow-up for as long as a year, to counsel with the patient on problems of adjustment in the job situation, and to stand by until he is satisfactorily adjusted.

Consideration of this data leads to the need for scrutinizing and possibly reorienting the function of the departments of occupational therapy in psychiatric hospitals. Occupational therapy need not be only avocational; it can have pre-vocational and vocational goals as well. Experiments of this kind carried out during the war proved that many psychiatric inpatients can be regularly employed while they are still under treatment. We need a further extension of these kinds of development.

Vocational rehabilitation is a reality, the opportunities of which are largely ignored by our psychiatric hospitals, both public and private. We have sufficient knowledge as to how to plan for them. Such programs will obviate the kind of advice given to a recent patient upon her discharge from the psychiatric hospital: "Now you are cured. Go back home and find your niche."

Conclusions and Recommendations

1. Vocational rehabilitation of the psychiatrically handicapped is a long-neglected psychiatric responsibility.

2. Vocational rehabilitation is a reality made possible for the psychiatrically handicapped by the Borden-LaFollette Amendment to the Federal Rehabilitation Law on July 6, 1943.

3. Studies in four state hospitals and three states reveal a sizeable need among psychotic patients for such services. Methods of implementing such programs have been worked out.

4. Every psychiatric hospital should consider as its treatment goal the reintegration of the patient back into the community, and the task should not be considered finished until

full vocational reintegration is completed as far as one can go with any individual patient.

5. Such a program must include the return of each employable patient to gainful and satisfactory employment. This neglected aspect of rehabilitation needs planned attention by psychiatrists. The task must be met before the patient leaves the hospital.

6. The state agencies exist by which satisfactory vocational rehabilitation can become a reality. Hospital and community agencies must work closely together on the program to insure its full success.

7. A vocational counselor should be available to the staff of every private and state hospital. His work is greatly facilitated by working as a member of the hospital team and by establishing his relationship with patients prior to their discharge. Pre-vocational and vocational programs need developing within the hospitals to supplement much of the occupational-therapy programs now in use.

8. Vocational rehabilitation demands integration of efforts by psychiatrist, social worker, rehabilitation worker, and community agencies.

THE AGE PERIOD OF CULTURAL FIXATION *

WESTON LABARRE, PH.D.
Associate Professor of Anthropology, Department of Sociology and Anthropology, Duke University

MODERN anthropologists are increasingly coming around to the point of view of modern dynamic psychiatry—especially that of analytic psychiatry—that the essential conditioning of children, in other tribes as well as in our own, belongs to the very earliest years of the infant, perhaps even essentially to the first few years of life. Let me cite a fragment of the kind of evidence that is convincing us of this.

For example, all the field workers among the Hopi Indians—whether psychiatrically sophisticated or not—have remarked on the curious fact that even very young Hopi children, when playing together, do so with great peacefulness and an amazing lack of squabbles and outcries—in a manner, in short, that is almost wholly different from the familiar behavior of children in our aggressive, competitive, individualistic society. Phenomena of this kind are so striking that the earliest theorists felt it necessary to postulate actual racial differences in national temperament or character structure, to account for the presence of these traits in the very young. Now we see that the racial argument is inadequate both inclusively and exclusively: first, other Pueblo tribes, with *different* origins from the Hopi—say, the Zuni—show the *same* traits in their children, so that this must be in some way a question of cultural areas. Secondly, the Comanche Indians of the Plains, who must have had the *same* ultimate origins to the northwest as the Hopi, are by contrast among the most freely aggressive, competitive, and individualistic people one could hope to find on the entire continent. Hence it is improbable that inherited racial characteristics have anything to do with the phenomenon.

* Presented at the session on "Positive Mental Health" at the Thirty-ninth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 4, 1948.

The explanation modern anthropologists find most adequate is essentially a psychiatric one. We believe that the basic character structure of individuals in a society which marks them off from other groups must be something that is learned or inculcated, something that inheres in the process of socialization, something that has to do with the culturally patterned ways that peoples have of bringing up their children. Thus the very great importance of the age period of cultural fixation is evident. To the extent that we have stereotyped ways of bringing up children, to that extent will we have stereotypes of preferred character structure in the adults of that society. Those traits that form what we might loosely call "national temperament" are really the resultants of different tribal pedagogical techniques. In other words, the least common denominator of temperament found in the members of a group is the product of the similarities of their conditioning as infants, similarities in culturally defined child-rearing techniques.

Incidentally, in the case of the Hopi and other Pueblo Indians, the answer is fairly clear. The Pueblo Indians, who, for economic and military reasons, have long had to live together in urban groupings, have developed highly effective ways of minimizing the open expression of aggressiveness between individuals. Pueblo adults are markedly subdued and restrained in their aggressions. True, they almost never give any corporal punishment to their children; nevertheless, even tiny Pueblo children show the same submissiveness and mildness and apparent lack of aggressiveness. The final reason, very likely, is the Pueblo technique of frightening and controlling children through certain religious practices. These, in brief, involve the *kachinas*—tribesmen dressed up to impersonate the gods—who come ceremonially to the tribe at certain times and whip the children. All of those who work with children will agree, I think, that being whipped by the very gods might be conducive to the early and stringent control of aggressive feelings! We do not need to assume any racial differences in endowment of aggressiveness, when it is so clear that there are such different cultural demands for the control of aggression.

Anthropologists like Sapir, Mead, Bateson, Dollard, Bene-

dict, Linton, and others have now piled up a mountain of evidence for the correctness of the psychiatric explanation of differences in character structure or "basic personality type" among various human societies. It seems to me that this is potentially one of the greatest scientific discoveries of modern times, not only to mental hygienists, but to every citizen of the world. *The single most important thing in human cultural behavior is literally and specifically the way we bring up our children.* And the single most important thing ultimately in the politics of the world is the *kind of human being,* temperamentally, that we manufacture.

Shall we, out of the supposed necessities of a Soviet society, manufacture people who are characteristically so persecutory, so suspicious, and so determined to disagree with other human beings whom they categorically and stubbornly define as their mortal enemies that international society will be impossible? Or is it a fair demand that we somehow manufacture world citizens who can at least communicate with one another concerning their real differences? It seems to me that this crucial problem of the cultural and psychiatric techniques we have for conditioning and structuring human beings will profitably occupy the best efforts of mental hygienists, psychiatrists, social workers, psychologists, sociologists, and anthropologists alike for some time to come.

Let me cite another kind of evidence, of a sort with which we who are interested in mental hygiene are most familiar. This evidence points to a fact upon which I am sure both psychiatrists and anthropologists can agree: cultures, so to speak, manufacture their own misfits; societies have the maladjusted they deserve. That is to say, no human being is ever maladjusted to thin air, but only to the specific cultural and moral demands of a given society. If cultures corset human beings in differing ways and at different points, then we must expect the bulges to show up in different places. We must expect to find different psychiatric and social maladjustments in different cultures. This seems to be precisely what, as anthropologists, we do find.

In odd corners of the world, field workers these last hundred years have been repeatedly stumbling over bizarre

native psychoses which appear not wholly to fit the categories of our Kraepelinian psychiatric system. There was, for instance, the famous "running amok" in Malaya among males, and a corresponding psychosis among females called "latah." Although Kraepelin himself noted these, no one yet has definitely equated them with epileptic equivalents, catatonic rage, hysteria, or any of the other familiar clinical syndromes of Western culture. The famous "arctic hysteria" was early reported from Siberia, but the early ethnographers who observed it were insufficiently versed in the clinical symptoms to look for, with the result that we have no very exact information about it clinically. Any one conversant with medieval Scandinavian literature has had his curiosity whetted as to just what "berserker rage" was medically; and Freud himself, in 1923, wrote on "A Neurosis of Demoniacal Possession in the Seventeenth Century," a disorder that is no longer found among us.

It has become clear that even the most careful descriptions and categorizations of European patients do not exhaust the possibilities of psychological maladjustment among human beings. The reason is that mental illness of the functional type is not so much a somatic disease as it is a psychological disorder, with an undeniable cultural dimension. What I am saying is that a functional mental illness is a disease of the *mind* primarily, not of the *brain;* it is a disease of the *social* animal, not of his body. Thus the remedy is not to be found in such pseudo-hard-boiled approaches as surgical mutilation of the brain or a rice diet, but rather in the sociologically sophisticated *prophylactic* approach of the mental hygienist and the dynamic psychiatrist.

Again, what of the curious "windigo" psychosis of the Cree Indians of south-central Canada, in which the person believes himself possessed by the spirit of a cannibal giant and rushes around obsessed with a desire to eat human flesh, even that of corpses? I suppose that one of the incidental aims of therapy here would be to persuade the victim to change his diet, but I am not quite clear whether we should attack the frontal lobes or the hind-brain in amputating this psychosis surgically. Surely there is a considerable *cultural* coloring to this psychosis, for it occurs only within certain

aboriginal-culture areas on a map! Furthermore, Freud predicted—and his prediction has already partly come true—that certain types of nineteenth-century neuroses would become rare as the lay public became gradually more familiar with the findings of modern psychiatry. Certainly "chlorosis," or "the green sickness," is not a common complaint among us now. I think we can attribute this change largely to the efforts of a mental hygiene which has modified and ameliorated some of the savage psychological pressures upon the nineteenth-century female, who was, after all, a mammal like the rest of us.

Or take the case of the Chinese. Psychiatrists have long known that certain cardiac disorders like hypertension were statistical rarities among the Chinese. Recently there has been a suggested therapy for hypertension which to my mind wholly misses the issue. The reasoning is something like this: the major premise, Chinese do not suffer from hypertension to the extent that Occidentals do; minor premise, Chinese eat mostly rice; therefore—conclusion of the syllogism—the cure for hypertension is rice-eating! The point is entirely missed that the Chinese lack of hypertension may be largely owing to a different character structure, culturally different goals, a radically different tempo of life, and pretty completely different modes of socializing and conditioning children. Chinese do not have hypertension because they are *not tense*, are not compulsive; not because they eat rice. They have different culturally conditioned attitude-stances toward life, and different institutional structures.

There was an old army man in the 1890's, James Mooney, who was involved in the Sioux wars—the Battle of Wounded Knee and Custer's Last Stand—who, from a lifetime of experience with various Indian tribes, came to the kind of understanding that I think is essential to the issue.

> "The Sioux [he says] are direct and manly, the Cheyenne high-spirited and keenly sensitive, the Arapaho generous and accommodating, the Comanche practical and businesslike."[1]

And the reason clearly is that the Sioux, the Cheyenne, the Arapaho, and the Comanche have different ways of bringing up their children, for all the fact that they are equally buffalo-

[1] See "Calendar History of the Kiowa Indians," by James Mooney, in the Seventeenth Annual Report of the Bureau of American Ethnology. Washington: United States Bureau of American Ethnology, 1898. p. 234.

hunting Plains Indians. Americanists have long known that the Plains Indians in general are individualistic, competitive, and extraverted, in contrast to the introverted, philosophical, and somewhat mystical Algonquians of the Eastern woodlands. In fact, that characteristic religion of the Plains Indians in historic times, the Sun Dance, appears originally to have come from an Algonquian source. Also we know that the messianic new religion of the 1890's, the famous "Ghost Dance," found a different reception among different Indian tribes, some of whom were fine aboriginal skeptics, while others swallowed it whole cloth. Even the susceptibility of different tribes to the use of alcohol is widely different, and probably for cultural reasons; and the same is true when it comes to the spread of the modern religion of peyotism, which involves the use of a narcotic cactus in religious rituals.[1]

The clues are there in the culture. If the Zuni child is frightened nearly to death by the masked "gods" who actually materialize in the rituals and whip him, is it any wonder that the Zuni adult is deeply inhibited, secretive, mild-mannered, and physically non-aggressive? The Aztec were an exaggeratedly apprehensive people, filled with fear, but this is fully understandable when one reads in the old Spanish writer, Sahagun, of their brutal punishments of children and their inordinately sadistic theocratic culture, replete with frequent human sacrifice.[2]

One could multiply these examples indefinitely. The Navahos are "gloomy and morose, yet, in spite of their apparent stolidity, they are liable to panic terrors, to epidemic neuroses, temporary hallucinations, and manias." The Eskimos of Siberia are a notoriously jolly, matter-of-fact, hard-boiled, and happy group; yet the Chukchi, who inhabit the identical physical environment, are insecure, resentful, and anxious. It is clear that these differences are not in the germ plasm, not in the environment, but in their differing tribal conditionings of children.

[1] See *The Peyote Cult*, by Weston LaBarre. (Yale University Publications in Anthropology, No. 19.) New Haven: Yale University Press, 1938.

[2] See *Aztecs of Mexico*, by George C. Vaillant (Garden City, N. Y.: Doubleday, Doran and Company, 1941) especially pp. 103, 110, 233, and 241–42. See also *Our Primitive Contemporaries*, by George Peter Murdock (New York: The Macmillan Company, 1934) pp. 359–402.

These differences extend even to questions of gross mechanical and other abilities. The Alaskan Eskimos take to machinery like a duck to water and are in demand as sailors on coastal steam vessels. On the other hand, it seems impossible to teach a Bengali Indian even a simple thing like driving a truck: he loses what little integration he may have had and deliquesces into disorganized panic in the face of that mystery, a machine. The Yaqui Indians of Mexico have a singular gift for machinery and are preferred as laborers by American engineers; yet mechanical ability is by no means characteristic of Mexican Indians in general. The Chinese are hopeless incompetents in the care and management of powered industrial machinery; yet their next-door neighbors, the Japanese, took over a machine civilization fairly completely in about fifty years. In the Southwest Pacific, the Papuan is given to a very easily aroused hilarity, while his neighbor in New Guinea is morose and taciturn—so much so that one can actually draw a line on a map of Oceania separating "Papuan hilarity" as a culture trait from "Melanesian moroseness." In the same Micronesian islands of the former Japanese Mandate, "Kanakas and Chamorros differ markedly . . . in personality structure the Kanakas are unaggressive, mild, and submissive while the Chamorros are militant, brittle, and explosive,"[1] which are matters of no little administrative moment. The Okinawans have an almost incredible fortitude and realism, and seem to lack neurotic anxiety to an amazing degree. The psychiatrist, James Clark Moloney, has fully documented in a long motion picture his thesis that this stolidity is owing to the rocklike security the Okinawan infant derives from its mother in its very first years.[2] The Aymara Indians,[3] on the other hand, a group I studied in the Lake Titicaca region of South America, have an almost panic apprehensive-

[1] See "Governing the Occupied Areas of the South Pacific: Wartime Lessons and Peacetime Proposals," by Lieutenant John Useem, U.S.N.R. *Applied Anthropology*, Vol. 4, pp. 1–10, Spring 1945.

[2] See "Psychiatric Observations in Okinawa Shima," by James Clark Moloney (*Psychiatry*, Vol. 8, pp. 391–99, November, 1945). See also his "On Oriental Stoicism" (*American Journal of Psychiatry*, Vol. 103, pp. 60–64, July, 1946).

[3] See "The Aymara Indians of the Lake Titicaca Plateau, Bolivia," by Weston LaBarre (Memoirs of the American Anthropological Association, No. 68. New York: American Anthropological Association, 1948). See also his "Aymara Texts," to be published in the *International Journal of American Linguistics*.

ness, a sadistic and terrifying list of mythological creatures and legends, and have probably more different categories of doctors, diviners, and medicine men, as well as the exorbitantly largest *materia medica,* of any tribe yet known to science.

The implications of all these descriptive facts are clear, but somewhat alarming. It means that, whether he knows it or not, man has the key to his future evolution in his own unwitting and unready hands. Through anthropological and psychiatric knowledge and control of the bringing up of our children, *we are potentially able to shape almost any kind of human personality that an increasingly integrated world requires.* Shall we have a competitive, aggressive Comanche-like personality in our future world citizen, or shall we have an urbane, Hopi-like personality? It is not the knowledge, but the social implementation of it, that is lacking. Will we want the tenseness, the explosiveness, and the compulsive competence of the Japanese; or do we want the security and the aplomb and the realism of the Okinawans? Do we want the Chinese profoundly æsthetic enjoyment of life, or the severe, driving, guilt-ridden morality of Western man?

If it is the nature of human nature to be thus malleable, then, in the face of this fact, the atomic bomb, which is only a creature of man, itself recedes into secondary importance. The critical question is: What kind of character structure in humans is to exploit the behavior of atoms—a persecutory, apprehensive, insecure one, or a mature, non-paranoid, reality-assessing one?

The choices, we should be warned, are by no means always easy. Our misfits, it must be remembered, are the creatures of our own cultural idealisms. Does our medieval-minded culture continue somewhat to idealize celibacy? Then let us expect to pay the price for this in terms of hysteria and of paranoia. Is it a culture pattern for us to pretend that we are only a little lower than the angels, primarily spiritual creatures who are organically different from "the lower animals"? Do we wish to pretend that the synthetic motherhood of the old-fashioned male pediatrician and his bottles is superior to that old-fashioned mammalian invention, the breast? Dr. Aldrich is leading us out of this wilder-

ness; but until more and more of us listen to his kind of inspired common sense, let us cease to be surprised that our favorite psychosis, statistically speaking, is schizophrenia, which is a social illness of the affectively motherless. If we find it expedient to insist that man is an individualistic monad organically and culturally, then let us cease to wonder that we continue, all too successfully, to fill our mental hospitals with this kind of individual, whose very interpersonal humanity has been interfered with. We need to take an adult, cold-eyed view of our own sacred superego, our own sacred culture. It is our own most unassailable beliefs that are the cause of our direst miseries. So long as we pretend to be pure, disembodied spirits, so long as we pretend to hate our animal nature and its necessities, just so long will we continue to manufacture our favorite brands of neurotics and psychotics.

The place to start is at the beginning. Is our society loaded with anxious, frustrated, oral-dependent or oral-aggressive individuals, over-ready at the first breath of cold reality to retreat into dependency or an autistic dream world? Then let us look at societies in which such individuals are a rarity. In most primitive groups, for example, because of their pediatric backwardness and lack of Frigidaires, a child is ignorantly suckled a minimum of two or three years—and, worst of all, he is fed whenever he is hungry, in a hopelessly unscheduled fashion! (Some American Indians are permitted an occasional visit to the breast even up to the age of five.) Is the dignity, the inexpugnable security, the settled self-judgment and self-possession of such American Indians a surprise to us, then? I have known American Indians whom the threat of the atomic bomb itself would not disorganize; upon knowing the worst of all imaginable situations, they would continue to adjust to them. I know one American Indian who conducted himself through the terrors of a modern war with a really distinguished aplomb. We would mistakenly call it courage—for him it was something to be taken for granted like his own manhood; he simply lacked those reservoirs of neurotic anxiety which flood us in stress situations. He lacked the culturally defined guilts that would lead him irrationally to anticipate punish-

ment; he had not experienced the frustrations and hence did not have the hostilities to project and to be persecuted by as neurotic fears; he had not had his childhood ego systematically attacked and traumatized so that he had any doubt of his ability to cope with any current situation.

But let any future engineers of human nature know what they are doing. If they do not insist upon some minimal tonus of sphincter morality, they may get the fecklessness of the Chinese character structure along with its relaxation and exquisite æsthetic enjoyment. To apply these measures to our own society is even more alarming: we may have to give up socially valued sublimated drives if we are to edit and to revise our traditional sexual morality. The choices are by no means simple. The price of the non-stressful adolescence found in Samoans is the giving up of our exaltation of virginity and premarital chastity. Could we possibly do without our cherished official fictions that sexuality both should and does begin with the honeymoon? Is it not truly a shocking suggestion that the way to obtain sexual knowledge is to obtain sexual experience? Are we prepared to accept the consequences?

Social scientists have long complained that the experimental method is not open to them. This is a misplaced self-commiseration, for from the anthropologists' point of view, most of the imaginable possibilities—and many undreamed of—are to be found in one tribe or another in historical time or ethnographic space. There we find that many sociological experiments have already been made for us. And so far as that goes, there is a whole menagerie of cultural choices for us to make. Do we want a fanatic, compulsive loyalty to tribal values? Then let us make our puberty ceremonials as frightening as we can, complete with genital mutilations. Would it be convenient, for our purposes, to multiply incest anxiety, so that not merely a restricted few, but, instead, as many as seven-eighths of the females in a given tribe are tabooed to a given male? The Central Australian Bushmen have already shown us how to do this. Of course the price included circumcision, knocking out teeth, subincision, scarification of the body, ter-

rifying of initiates, ceremonial disenfranchisement of one-half the tribe, the burning of male genitals with a fire-stick, and repeated blood-lettings from the male genital. Not worth it, perhaps?

Do we value socially, then, religious mystics like St. Theresa or St. John of the Cross? Well, the ideals of medieval monasticism will turn the trick; go ask St. Paul or St. Augustine. Is the hysterical character socially valuable? Then let us by all means increase the burden of taboos concerning sexuality upon the females in our society. Do we want a military caste to defend the sacred values of our society, to cultivate a lust after the absolute that is not only incestuous, but homosexual? Then let us increase the exclusive narcissism of male values in the society, let us institutionalize homosexuality as did the Dorian Greeks, the German Nazis, the ancient Japanese Samurai, and let us accompany this with a systematic, reciprocal devaluation and dehumanization of the female and of the womanly.

Do we want peace at any price among tribes? Then let us manufacture nice compulsive Zunis, obsessed with urine and feces, to be sure, but no bother to anybody; possessed of Snake Dances, like the Hopi, but no international threat. Is loyalty to blood ties what we want? Then take the tip from the Dobuans of Melanesia; of course, the price for exclusive loyalty to kin is going to be the insecurity and the weakening of the marriage tie, and the hostility in marriage of persons of different clans, but consider the great boon you are getting for it—clan loyalty. Are the things of a spiritual other world our first concern, and not the material world here? Well, we do a pretty good job of manufacturing persons who have psychically left the real physical world behind them, but we might get a few useful pointers from Hinduism, though we must expect to get a large number of physical miseries as a by-product.

In this universe of value-geometries, man has a terrifying freedom of alternative selection. In matters of ethics, truly "you pays your money and you takes your choice." This is what Erich Fromm is saying in his great book, *Escape from Freedom.* This is what the great theologian Kierke-

gaard is saying. And I suspect it is what is meant in the Book of Genesis when the serpent says, "And ye shall be as gods, knowing good and evil."

With man, we have reached an emergent new *type* of evolution. Since his hands have been emancipated from walking, man no longer evolves new adaptations in his own body genetically; he makes his machines do his evolving for him outside his own skin. What the birds learned to do indifferently well in countless milennia since Archæopteryx, man has done better in the four decades or so since Kitty Hawk and the Wright brothers, and according to the latest newspaper reports, man now flies several hundred miles faster than the speed of sound.

Since he began to live together in social groups, man has also emancipated himself from the principle of evolution, the individual survival of the fittest; and through the control of his own food supply, he is a self-domesticated animal who has produced all sorts of non-adaptive racial characteristics. Unlike other successful animals, man is not undergoing radial adaptation: one race is not evolving its finger nails into screw drivers, while another is making knives of them and still another chisels. In the last million years man has not made any important physical specializations at all. As a mammal, far out on a peripheral limb of evolution, he is the heir of all the brilliantly successful inventions of his animal ancestors: he has solved most of the problems of bodily housekeeping, chemical and physical; and problems of nutrition, reproduction, chemical and heat homeostasis, oxidation, removal of wastes, storage of foodstuffs, and the like are so well taken care of that most of these processes are not even problems of consciousness.

In the last analysis, every culture is ultimately a moral stance or a system of ethical choices; and man is actually free biologically to make alternative choices of his future evolution. The important differences among groups of men are those of their value systems, the things they believe in, their attitudes and behaviors—in short, the things they want to be. The making of moralities is the spear point of human evolution, the forging of adequate human relationships, the

achievement of higher integrations of human beings. As the obedience to chemical and physical laws in his body has given the human being a greater freedom to be human, so a disciplining to an adequate morality of relationships among persons and among groups will be an accentuation of human individuation and effective human freedom. Just as the regulation of behavior in the sexual sphere within codified tribal marital moralities is really an emancipation of sexual love which has permitted the relationships of men and women to become something profounder and more worth while than promiscuity and social chaos, so also will socialization to an international culture with truly human dignity be an emancipation, a further enobling of life.

Competing for survival in the human world are value systems, not individual human beings; adequate human character structures as expressed in group life, not individual animal survival. An appropriate human ethos is the thing that is struggling for survival. And in this process—I come back to it—the really serious thing is *the kinds of human being* we make, and *the ways in which we go about making them.* The child, we say easily, is the father of the individual man. But more than that, in this larger sense, *the child is the father of all future mankind.*

TEAMWORK FOR THE YOUNG CHILD*

ELIZABETH GORDON FOX, R.N.

Executive Director, Visiting Nurse Association of New Haven, Connecticut

THREE professional persons are closely involved in the birth and early experiences of the little child: the obstetrician, the pediatrician, and the public-health nurse. All three ideally play a rôle before he is born and during the neonatal period, and the pediatrician and the public-health nurse thereafter. The extent of the influence of each of these professional persons depends, among other things, on his or her initiative in taking a human interest in, and seeking to be helpful to, the parents; on the time available; and on the individual mother's choice of an adviser or confidant. Her choice may be consistent or opportunistic, or she may seek advice indiscriminately from all three.

It is obvious that this situation of having three potential sources of information, suggestion, and counsel can fortify the mother, or can greatly confuse and frustrate her. The greater the range of common interests, the greater the possibility of some disparity of advice unless there is mutual understanding among them.

This paper attempts to suggest some of the aspects of mental hygiene for the child that may be of mutual concern to the obstetrician, the pediatrician, and the public-health nurse, and to stress the need for correlation of function and, even more, for philosophical agreement. We shall not attempt to broaden our theme to include other professional persons who might well be considered as members of the team, as, for example, the hospital nurse, the medical social worker, the nursery-school teacher, and the family-service worker. Neither shall we include the psychiatrist and the psychologist. We are confining ourselves to the three who

* Presented at the session on "Positive Mental Health" at the Thirty-ninth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 4, 1948.

most frequently play a basic rôle in the early life of every child.

The topic of this session is "Positive Mental Health," and we shall confine our remarks to the field of mental hygiene.[1]

This paper is based on certain assumptions, to wit: (1) that, of the various influences that mold the child's pattern of behavior, the feeling that exists between him and his parents is one of the most potent; (2) that the chances that a happy relationship will develop between the child and his parents are better when the parents are emotionally free to love their baby, and to be natural with him; (3) that tension is less likely to develop when the mother is in good physical condition, and both parents are as emotionally secure as the situation permits, and when they feel reasonably able to cope with the baby's creature needs and little upsets; and (4) that obstetrician, pediatrician, and public-health nurse can help to foster the emotional security and the confidence of parents in their own ability, and that this is one of their prime responsibilities.

In order to demonstrate the need for teamwork and to indicate some areas in which it is important, it seems necessary to say something about what is being done by members of the team to promote parental peace of mind. We shall discuss pregnancy, the neonatal period, and infancy and early childhood in turn.

One of the important pressure points that affect the parents' future relations with their baby is their mental and emotional reaction to pregnancy as a physical phenomenon. Usually, we believe, there is some fear for the mother's life and for that of the baby, born in part of ignorance and misinformation and of frightening tales. Sometimes fear is more deep-seated. Ordinarily there is dread of pain during childbirth, partly because women have been taught to believe that pain is inevitable. Often there is some worry, even considerable apprehension, over natural phenomena of pregnancy which are not understood.

[1] In compiling these ideas, we have had the generous advice of Dr. Grover F. Powers, Professor of Pediatrics, Yale Medical School, and of Dr. Frederick W. Goodrich, Jr., Senior Associate Resident, Obstetrical Department, New Haven Hospital, but we do not hold them responsible for our remarks.

Another pressure point affecting future parent-child relations is the emotional reaction of the parents to the coming of the baby. Probably all women have some ambivalence, which they may think unnatural and try to conceal. Sometimes there is actual rejection, either conscious or unconscious. Some women dread the coming of the baby because they feel incompetent to care for him, knowing nothing of child care. Some may have strong feelings for or against nursing him. There is bound to be emotional stress if the mother is unmarried. A pregnancy late in the child-bearing period, after other children are well grown, may be a deeply disturbing event. The mother who has had repeated miscarriages often is unwilling to think about or to prepare for the coming baby for fear of renewed disappointment.

These fears and worries and feelings of ignorance and inadequacy are scarcely conducive to peace of mind and emotional balance, and, therefore, are not good preparation for creating an easy and assured relationship with the baby. This is being increasingly recognized by obstetricians, pediatricians, and public-health nurses alike, who are making an effort to lessen them.

The simple step of telling patients about the physiology of pregnancy, the course and mechanics of labor and involution, the rationale of hygiene, and the preparations for the care of the baby, has done much to overcome misinformation and, in large measure, fear and dread of the unknown. Such teaching is being done by some obstetricians and by some obstetrical-ward nurses to groups of women, and through individual consultation. It is also being done by those visiting-nurse associations that carry on a regular program of classes for pregnant women, and who give them much individual demonstration and instruction in their homes. For patients who are interested and who would profit by reading popular literature on this subject, suitable books and pamphlets are recommended.

In one institution at least, this careful preparation, plus the feeling for the individual that goes with it, has made it possible to conduct many successful deliveries without anæsthesia, and with the cheerful coöperation of the patient, so largely has fear been overcome. In this same institu-

tion, breast feeding is more and more encouraged by the matter-of-fact attitude of the obstetrician and the pediatrician of expecting it. Experience here seems to show that many women warmly welcome this return to the natural way of having a baby and of feeding him.

This is not to say that nursing is insisted upon, or that a mother is made to feel somehow at fault if she does not nurse the baby. The anxiety generated by pressure to follow a course that she cannot accept, is clearly recognized, and she is given full support in procedures that meet her emotional needs.

In their regular contacts with the mother during pregnancy, the physician and the nurse try to learn something of her individual psychological make-up and her personal reactions and needs and, through friendly, uncritical acceptance, to give her as much security as possible. Much can be done for many women through this warm interest and understanding support. Occasionally, however, the roots of emotional turmoil lie too deep to be met in this way, and psychiatric help is needed and recommended.

This leads us to the neonatal period, where the pattern of the baby's behavior begins to take shape. Some of the factors that go into the shaping of this pattern are the feelings of the mother and father about the baby, both when he is normal and when there is some or much abnormality; the mother's desire to have her baby with her as much as possible and to give him care, or her feeling of unreadiness for this; her attitude toward nursing the baby and her acceptance of "self-demand," or her need to have a schedule to follow; the emotional support of her husband or the lack of it.

And when she goes home, there are the added factors of the degree of tension and calm prevailing; the course of her convalescence as it bears upon her ability to care for her baby; her ease and confidence in caring for him; the ready availability of medical guidance and the help of the public-health nurse; and recognition by physician and nurse of her need for reassurance about countless little things about the baby that can assume frightening proportions to her inexperienced mind.

One of the major developments of recent years, in response

to recognition of the great importance of these emotional reactions, is the so-called "rooming-in" program. This program embraces much more than the mere mechanical change of allowing the mother to have her baby in the room with her. It is characterized by a way of thinking about the patient as a personality embarking on a great undertaking—the rearing of a child—longing to have her baby with her, to get acquainted with him, and to do for him. This is equally true of the father. The program aims to give them every possible support that will meet this natural yearning and will add to their sense of security in their rôle of parents, and to their enjoyment of their baby. Part of this security is gained through the practical help the mother is given in learning how to feed, handle, and bathe the baby. The rooming-in mother has a great advantage here, too, as she learns to do these things by actual practice under the helpful eye of the nurse.

For other mothers, informal group teaching and demonstration may be carried on in the ward. Many of them, during their pregnancy, have attended a series of mothers' classes given by the public-health nurse, in which all these things were taught. The public-health nurse would be the first to testify, however, that teaching in the abstract cannot compare with the learning the rooming-in mother attains through the actual care of her baby under supervision. The public-health nurse would also testify that these mothers are usually much more relaxed with their babies.

Perhaps we should stop at this point and consider the need for teamwork among the members of the team that has emerged thus far. First and foremost is the need for a common understanding—a common understanding of and agreement about the meaning and importance of parental feelings before and after the baby comes, and the prime necessity of fortifying the confidence of parents in themselves, so that they may enjoy their baby to the limit of their capacity to do so. Then there must be agreement in general attitude toward natural childbirth, rooming-in, breast feeding, and self-demand. Added to this there must be shared understanding of the individual patient's emotional needs and consistency of approach to these needs. Finally, there must be harmony in what is taught to parents both

in factual content and in the philosophy that guides the teaching. Clearly, the same climate of opinion must prevail throughout the obstetrical and pediatric departments of the hospital and, so far as possible, between obstetricians and pediatricians outside. And there must be the habit of consultation and agreement wherever possible—with compromise when necessary—in dealing with particular patients throughout the pregnancy and the neonatal period.

The same thing is true as regards the public-health nurse. Perhaps more than is generally realized, she is a power for good or for harm. Often she is serving a considerable number of families in which there is pregnancy or a new baby. If she is a warm, receptive, and uncritical person, mothers will often shower her with questions and pour out their emotions with a freedom they might not have with the physician. She is forced to respond in some manner, and her response can be exceedingly helpful or quite unwittingly hurtful. If she is well teamed up with the physician, there is little danger that her response will be so different as to be confusing; on the contrary, it should be greatly sustaining. Moreover, her on-the-spot observations may afford the physician an insight into the patient's feelings, the little things that are troubling her, and the relationship within the family, that would be of great assistance to him. Clearly, she must have the same understanding of human behavior that he has in order to further his efforts.

As the child grows, his parents are usually full of questions about him. They are concerned about the course of feeding and weaning; about his little or big deviations from his usual routine of sleeping and napping; about how long to let him cry, and the fear of spoiling him if they pick him up; about his play and toys and reactions toward his siblings and playmates; about toilet training; about sex interest; about his behavior in illness; about his maturation and growth and the phases of his development; about ways to help him become a healthy social being.

Parents want both understanding and practical guidance, and they seek them from many sources, but especially from their pediatricians and public-health nurses. Many of them are more or less aware of modern thinking about the importance of all these things in their child's growing personality,

and may be frightened by their responsibility. The thirty-five-cent edition of Dr. Spock's book has had a wide sale, and is being read by grandparents and aunts and uncles as well as by parents themselves. And many are familiar with Gesell's books.

Just because there is so much popular instruction in books, pamphlets, magazine articles, newspaper columns, and on the radio, there is all the more need for wise guidance in applying a mass of only partly digested ideas to the individual child. The primary responsibility for providing this guidance belongs to the pediatrician. But there are a thousand and one little things that come up from day to day that may not seem important enough to bring to the physician, but that mothers do not hesitate to tell the nurse about if she is good at listening and gives them the feeling that she is interested in hearing about them, and has time for it.

If she is playing a lone hand, even though she be well versed in modern thinking about child care, the nurse can unwittingly add to the mother's confusion by giving explanations and suggestions that differ slightly from those given by the pediatrician. If, on the contrary, she is working closely with the pediatrician and knows what he wants to accomplish and how he is proceeding in a given situation, she can greatly strengthen his hand and increase the mother's confidence in herself. Again, as during the prenatal period, her on-the-spot observations may afford the physician valuable clues to the true nature of the situation. Furthermore, she may be the first to notice symptoms of potential maladjustment in its incipiency, and by calling them to the physician's attention—in some instances, encouraging the mother to do so—can insure early treatment.

In short, no matter how professionally expert both may be, pediatrician and public-health nurse may inadvertently get their wires crossed if they are not working as an understanding team. While we are speaking of the contribution of these professional members to the parents, we do not want to imply that theirs is a one-way street. We are constantly aware that the parents themselves are members of the team, giving as well as receiving.

Whether and how much parents can be helped through group teaching in child rearing are questions that need

analysis and exploration. Parents' classes are springing up here and there under the ægis of visiting-nurse associations, family-service agencies, nursery schools, and others.

Because most parents are concerned with their own experiences with their children and are eager to discuss them, and because, back of this interest, there are often their own unsolved emotional conflicts, some deeply understanding pediatricians feel that discussion periods may be futile, if not actually dangerous. Can technics be developed to minimize, if not altogether to eliminate, these risks? Perhaps we might agree that instruction can safely be given to groups along the lines of the child's normal development, his physical growth, his linguistic ability, his emerging personality, and the phases that all children pass through. But the discussion of individual behavior is another matter. It would seem that child psychologists and psychiatrists, pediatricians, and public-health nurses need to get their heads together on this matter, and to come to some agreement on such questions as: Who will benefit by group discussion? How small must the group be? Must it be homogeneous? What content can safely be given? What technics are most effective? And who should the teachers be?

What we have been saying, then, amounts to this: that the obstetrician, the pediatrician, and the public-health nurse have priceless opportunities to help parents feel more secure and happy with their children, and each has a valuable contribution to make; that to make the most of these opportunities, the three must work as a team, reinforcing one another in every possible way; that this calls for mutual respect for and confidence in one another, for intimate knowledge of one another's functions, philosophies, and procedures, and for direct interchange of ideas concerning individual patients. It would be enormously helpful if they all knew each other personally. Since this is not possible with large staffs, some of whom are working in the hospital and some in the field, the next best thing is to make sure that the responsible leaders, at least, are in close personal touch with one another with respect to every phase of their common task of helping to give children a healthy and happy start in life.

TEAMWORK FOR MATURITY*

ALICE V. KELIHER, PH.D.
Professor of Education, New York University

CHISHOLM has aptly said, "So far in the history of the world there have never been enough mature people in the right places. We have never had enough people anywhere who have been able to see and accept [these] facts and who are sufficiently well developed and responsible to tackle [these] problems."

While I have been asked to—and intend to—concentrate on the adolescent and the young adult, I want to comment briefly on the great importance of the years from nine to twelve in the development of the mature personality. In school, we see many manifestations of psychological weaning from adults in those years. Children apparently delight in throwing over the family rituals of cleanliness, punctuality, polite speech. Parents despair over the crudeness and resent the child's many acts of rejection. Unless the parent is helped to see its normality, there may be real conflict over the "Keep Out. Do Not Enter" signs that appear on the child's door. Parents need, too, to have interpreted the need of this age to turn to its own age and kind.

What seems to happen in this period is an inner declaration of emancipation from parental *yeses* and *noes.* If the child is ever to internalize these, and to learn to say them for himself at the right times and in the right situations, he has to try them for himself. Like all new learnings, he has to practice them. He learns that it is not safe to try his new powers on adults. The safest group to practice on is that of his own age and sex. I stress this period of development, for this transition from home control to peer control is an essential step in maturing into an independent person.

While I say that parents need help in interpreting the normality of the many unlovely acts of this period, teachers

* Presented at the session on "Positive Mental Health" at the Thirty-ninth Annual Meeting of The National Committee for Mental Hygiene, New York City, November 4, 1948.

need it more. Unfortunately, most school programs build up like stair steps toward a more and more academic day. The younger the child, the more content are teachers and school planners to let him live an active, socialized life, full of real experiences and play activities. But especially in the middle grades, from fourth to sixth, heavy academic demands are laid upon the children. Their classrooms become formalized. Their opportunities to live out their new search for independence are almost nil. It must be primarily an out-of-school experience. There are exceptions. Teachers who live by what they know of child development plan the program and the social organization in these years to foster, not to inhibit, the child's growth in independence.

Moving into the teen years, we see the same academic requirements making increasing demands on the growing youth. In the middle grades, he usually had one teacher piling on the demands. In high school, he usually has five or six, each of whom thinks that his subject is the one that should have home-work priority. I talked with a group of deeply sincere high-school students, who said that if they faithfully did all their assigned home work, they would spend four hours a night at it. You can figure their day. If they do any extracurricular things at school, and if they get in even a little of sociability on the way home, they get home at 5 or 5:30. They eat at 6:30 or 7. Four hours of home work, if they do it, adds up to a day that is too much for good physical health, not to speak of the guilts and anxieties engendered if edges are cut or if the child is not able to encompass it all.

One of these young people said, kindly, "You can't blame the teachers that they have to teach subjects first and students next."

The main objection to all this is that the adolescent is kept in the subservient rôle of constantly having to accept and to execute assignments that he has had no part in planning, and, as the above youngster said, in which the teacher, too, had little or no voice. This certainly whittles down the full opportunity for both to develop maturity.

A second problem for the teen-ager is how to get more and more responsible experience in self-government. The

pattern of monitors keeping you in line, demerits, visits to the principal's office, suspensions, and even corporal punishment still persists in many high schools. Rules, many of them petty, most of them handed down from some authority—often in the past—have to be obeyed. This, too, certainly prolongs an infantile relationship of teen-ager to authoritarian adult. Good high schools are becoming more and more aware of this problem. Student government is real, representative, and charged with tackling real and important problems.

This leads to a third problem for teen-agers—their need for effective vocational orientation. Here teamwork of school, industry, and community are as vital as in the other fields. Most youngsters in our country have to make their vocational choices while in high school. Indeed, in large communities in which there are specialized high schools, these choices have to be made at the end of junior high school or in the eighth grade. This means that a boy or girl of fourteen or fifteen has to make a choice that profoundly affects his future happiness and security.

I had an all-day meeting with the junior-high-school principals of a large city. All agreed that a large proportion of their graduates were not ready to choose wisely which of a variety of specialized programs they should embark upon. This city has a series of specialized vocational high schools, which grew out of a sincere desire on the part of school planners to give youth a really good preparation for their chosen work. But this presupposes—doesn't it?—that a fourteen- or fifteen-year-old is ready to make a definitive choice. There is a deeper supposition and that is that preparation for a work life in a school devoted to that particular career is also good preparation for the best possible life as a mature person and citizen.

Here, again, I can point to schools that are collaborating effectively with industries and services in giving boys and girls rich opportunities for vocational orientation. We all know the Antioch plan on the college level, which alternates periods of work and study. Some high schools are working out coöperative plans with local industries and services. Young people have a period of work, then return to school

for study and evaluation. On the junior-high-school level, schools are developing programs for visiting and coöperating somewhat in various fields of work.

Back of all this is our great concern for doing the best job we can of screening people for the right life work. We simply *must* rid ourselves of a Puritanical notion that once we have made a choice, we must stick with it or lose face. But the corollary of this is that we must begin much earlier experiencing and studying the various choices. If young people come to the end of study for a baccalaureate degree, as far too many do, never having had real opportunities to try themselves in the various fields, they may make unrealistic decisions that can lead only to future unhappiness for themselves and for others. For example, I am greatly concerned that people coming into my profession of teaching shall be those who can work positively and constructively with others; that they shall be mature, healthy personalities. From junior-high years on, experiences in baby sitting, camp counseling, assisting in play groups and settlements, and many other contacts with children should serve as content for discussion and guidance. It's pretty late when they come to us in their twenties saying, "No, I've never worked with children, but they tell me there's a shortage of teachers and I'll be sure to get a job."

In other words, in my field—and, I suspect, in most others—screening should not be something that happens once and then as it so often does, determines the person's life fate. Screening should be something that goes on for years before final decisions have to be reached.

Here, guidance counselors in schools, industries, and services should get together and pool their knowledge of the personality needs in various fields of work as well as the skills and dispositions that should be part of the education. These same counselors would do well, too, to study the trend toward earlier preparation for "type of occupation," with later selection of the specific field. Furthermore, frequent joint meetings and pooling of experiences would assist schools both in assessing persons and helping them to make wise choices, and in bringing about fundamental changes in the school program.

This subject of teamwork for maturity is vast. Fortunately your planning committee asked me to concentrate on the theme, "The Teacher and Industry," else I would have meandered in this important field more than I already have. There is yet the whole exciting subject of mental hygiene in industry—the growing use of case-workers in industries in which accidents and breakdowns can be avoided by a preventive approach. But that is a subject for another paper and for another person. Let me summarize the points at which I feel our current frontier jobs lie in building for maturity:

1. Better understanding of the importance of the "middle age of childhood" as a basic period in achieving independence.

2. High schools less dominated by an immaturity-prolonging pattern of assigning "lessons," and giving more and more time to genuine life experiences which students shall have a mature and responsible share in planning.

3. High schools in which young people shall have genuine experiences in self-government concerned with real matters of concern and genuine issues that touch their lives.

4. The addition of a rich and prolonged period of exploration into various fields of work with more active participation as well as more evaluation of the personality factors basic to happiness and effective work in various careers. Here the coöperation of community, industries, and services must be enlisted to help provide arenas for work and study and also to keep before the schools a realistic view of what the real essentials are. We need teamwork, too, if we are to develop adequate methods of screening and reorienting people toward the best life for them.

We do not know statistically how many of our large number of emotionally ill people were misfits in their jobs—made poor and inadequate life choices. We do know that failures in jobs come only in small measure from lack of skills, and

primarily from lack of those personality qualities that add up to maturity and effectiveness as a person.

The maturity Chisholm seeks will come in part because people have learned to stand on their own feet and to say their own *yeses* and *noes;* have helped to plan their own lives constructively and consciously to develop the best use of their own potentialities; have had positive experiences in self-government, with the opportunity to help establish as well as to accept law and order; have had rich experience with the work life of the world and ample opportunity to assess their own strengths and personality commitments. If we are to realize the potentialities in our people, we must work together to give them more and more opportunity for healthy self-direction, deeper insight into human needs, broader sensitivities, and consequent maturity.

SOCIAL SCIENCE AND SOCIAL ACTION: IMPLICATIONS FOR MENTAL HYGIENE *

SOL WIENER GINSBURG, M.D.
Chairman, Committee on Social Issues, Group for the Advancement of Psychiatry

IN 1930 a distinguished neurologist, Dr. Israel Wechsler, hurled a weighty challenge at the mental-hygiene movement and its workers in a paper entitled, *The Legend of the Prevention of Mental Disease.*[1] I can recall that meeting very vividly, a little more than eighteen years later. The hall of the New York Academy of Medicine was unusually crowded, and there was an air of strain and tension as those identified with the mental-hygiene movement, in whatever rôle, awaited the attack implicit even in the title of the paper. Dr. Wechsler's thesis was simple enough: How dare one talk of prevention when as yet nothing is known of the cause of mental disease? "Sad as it is to make the confession, the fact remains that, despite accumulation of knowledge, the ultimate cause or causes of nervous and mental disease is unknown."

And there was more: "Enthusiastic mental hygiene tells us (and I am quoting from actual statements) that it is concerned with the prevention of deficiency, criminality, the psychoneuroses, the psychoses, antisocial traits, family unhappiness, divorce, prostitution, alcoholism, sexual perversion, epilepsy, and other such simple matters."

I clearly remembered this stringent assault—which, its heavy-handed sarcasm aside, had that night unsettled not a few of us—when I was asked to speak to you about the social and economic implications of mental hygiene. It seems apparent to me that we must always be mindful that we

* Presented in slightly modified form, under the title, "The Social and Economic Implications of Mental Hygiene," at the Seventy-fifth Annual Meeting of the National Conference of Social Work, Washington, D. C., April 19, 1948. The paper is to be published in the Proceedings of the National Conference.

[1] *Journal of the American Medical Association,* Vol. 95, pp. 24–26, July 5, 1930.

speak of mental-hygiene matters as scientists, and that the allure of the easy generalization and the devout belief must be steadfastly resisted when they lie entirely outside our professional knowledge and competence.

It is especially difficult to maintain a firm hold on this necessity in such parlous days as these in which I write. All about us is the clamor of war and the threat of depression, and observers of all political and economic groups are agreed that there is more tension now abroad in our country than perhaps ever existed before. Thus, in an article fittingly entitled, *The Bewildered American People,*[1] Admiral E. M. Zacharias, whose work for twenty-five years in Navy Intelligence singularly equips him to discern the mood of a people, writes, "Since November 1947 I have been on the road. . . . What I found leaves me in an uneasy state of mind. The American knows that he is envied by the whole world for his economic well-being. . . . Yet he reveals insecurity deep in his heart. The optimism that was a great characteristic of the American people throughout its history has given way to a feeling of deep concern about to-morrow. . . . They [the people] expect something terrible to happen. . . . There is an undertone of fear."

Similarly, William L. Shirer writes,[2] "A recent swing around the lecture circuit left this correspondent with the uneasy feeling that our citizenry on the whole is in an almost shocking state of despair."

We are truly a frightened people and it is no wonder that we strain for help. The directions in which we can seek such help are few—the church, the family, perhaps the school, and psychiatry.

Which brings me, then, to a second aspect of our consideration: What is it that has made people in the United States so psychiatric-minded? The fact is unequivocal, if not at all with the meaning that Dr. Wechsler attached to it: psychiatry and its educational arm, mental hygiene, enjoy a vogue in this country that has never existed elsewhere or, for that matter, never to the same extent in this country. Obviously, this did not happen because American workers in

[1] *United Nations World,* March, 1948.
[2] *New York Herald Tribune,* March 14, 1948.

psychiatry are vainglorious and overseeking, nor is it entirely proper to say, as is frequently stated, that we have "oversold" the people on psychiatry. A prominent psychiatrist, Dr. C. C. Burlingame, has only recently bemoaned the fact that "hundreds of thousands of peoples, satiated with a superficial knowledge of the psychological implications of life and literally preoccupied with psychiatric terminology, are beginning to interpret every trivial thought and feeling in psychological terms." In the measure that this is true, it seems to put the cart before the horse and to ignore the need within people to seek psychological explanations. In whatever measure we have tried to "sell" psychiatry, it has been received with a spectacular avidity by the people, if almost always without any real understanding.

I believe that there are a variety of reasons to account for this enthusiasm for psychiatry in this country, an eagerness that not even the extraordinary travail in Europe has generated. We are, withal, a very young nation, and enthusiasm for a host of new things is one of our outstanding characteristics. In 1930, for instance, the year of Dr. Wechsler's paper accusing mental hygiene of overspreading itself, America was busy with Tom Thumb golf courses, so much so, in fact, that there were some who thought this new industry might substantially help relieve the depression that had followed the '29 stock-market crash.[1] That provides a suitable index of our capacity for enthusiasm!

We do not, as a nation, yet have a series of value systems and beliefs so integrated into our culture as to give us a firm basis of security which might protect us from the need to develop such infantile enthusiasms. Hence, any placebo for our social ills finds a ready audience, from frankly crackpot ideas to psychology, rampant. We not only have psychology for success in the "How-to-Make-Friends" tradition and psychology for utilitarian purposes, but more and more, as our anxieties seem to mount, we look to psychiatry for prescriptions and remedies for all sorts of ills, especially social ones.

A distinguished European social scientist, Siegfried Kra-

[1] See *I Remember Distinctly*, by Anna Rogers and Frederick Allen. New York: Harper and Brothers, 1947.

cauer, has recently emphasized just this need now so apparent in our country: to retreat from society to the individual.[1] Recent psychiatric publications deal with mental hygiene in the atomic age, with war and peace, with the varied and complicated problems of prejudice, especially with anti-Semitism, with delinquency and criminality—in fact, the list Dr. Wechsler offered as an exhibit seems as accurate as ever.

Dr. Brock Chisholm,[2] for instance, states quite explicitly, "Can any one doubt that enough people reaching maturity . . . would not want to start wars themselves and would prevent other people from starting them? It would appear that this quality of maturity, this growing up successfully, is what is lacking in the human race generally, in ourselves and in our legislators and governments, which can only represent the people. *This fact puts the problem squarely up to psychiatry.* The necessity to fight wars, whether as aggressor or as a defender who could have, but has not, taken steps to prevent war occurring, *is as much a pathological psychiatric symptom as is a phobia or the antisocial behavior of a criminal who has been dominated by a stern and unreasonable father*" (my italics). Thus, the whole complex problem of war, aggression, leadership, nationalism, and enduring peace is made to seem elementary for psychiatry and mental hygiene. *The Psychiatry of Enduring Peace and Social Progress* makes strange reading indeed in March, 1948!

Psychiatry is by no means alone in facing the dilemma of its social responsibility, although perhaps it needs to face it ever more realistically as the demands on it for activity in an ever-increasing variety of fields continue to mount. The question of the social responsibility of the scientist is hardly a new one; it received a fresh and important impetus with the advent of the atom bomb. Professor Fermi has described brilliantly the emotional impact of his first realization that the chain reaction was a certainty. Surely it is understandable that participation in the research and tech-

[1] See "Psychiatry for Everything and Everybody," by Siegfried Kracauer. *Commentary*, Vol. 5, pp. 222–28, March, 1948.

[2] See "The Reëstablishment of Peacetime Society," a symposium by C. B. Chisholm and others. *Psychiatry*, Vol. 9, pp. 1–35, February, 1946. Dr. Chisholm's paper was issued as a separate pamphlet under the title, *The Psychiatry of Enduring Peace and Social Progress.*

nology leading to the splitting of the atom would weigh heavily on those who had participated in it, especially once its theoretical destructive force had been translated into Nagasaki and Hiroshima.

I spent an evening not so long ago with four young scientists who had in one way or another participated in the work on the atom bomb. Theirs had been modest efforts indeed, and yet they bore, each of them individually, the terrific impact of guilt and responsibility to the extent that they had entirely forsaken their scientific endeavors and were busy trying to arouse the people of our country to the terrible danger of the bomb. They had decided the problem of the social responsibility of the scientist by disavowing the scientific life for which they had been trained for the rôle of propagandist, a "solution" that one may admire and yet seriously question.

Similarly, I am sure, social case-work faces this dilemma. In a recent issue of *Compass,*[1] Dr. Eveline Burns stated, with what seemed to me admirable lucidity, the dangers that are implicit in the confusion of our rôles as professionals and as citizens. As I understood her thesis, it was simply this: whenever we speak as professionals—especially when we do so about matters *beyond our own immediate professional knowledge and training*—we risk misunderstanding and, more importantly, we weaken our authority to speak and to act in matters genuinely within our professional range.

I have thought this long and fairly elaborate introduction necessary since the challenge of the subject offered for my consideration invites the type of easy generalization about which I have the strongest questions. It would be easy to list a whole array of social and economic problems that currently weigh upon us and to speculate as to their mental-hygiene implications—war and peace, unemployment, the threat of a new depression, the influence on women of industrial life, marriage and divorce, delinquency and crime, prejudice and segregation, universal military training, day care for children of working mothers, and so forth. But I have thought it wiser to speculate a while on the general problem and then take one or two examples to see how far

[1] That of May, 1947.

we dare venture with confidence to discuss their mental-hygiene implications.

Mental hygiene has been defined as "the science we apply in helping people to obtain and maintain mental health." In other words, the definition continues, "mental hygiene, like any other science, such as psychology, physiology, and so on, is a body of knowledge, and mental health is the condition which you hope will ensue from the application of the body of knowledge to the individual."

How does psychiatry acquire its knowledge? In three ways: first, through experimental evidence, which corresponds to what is traditionally recognized as scientific method; second, through empirical evidence, consisting of insights based on facts; and, third—and in this connection most important, since it is rarely mentioned or understood—through value judgments. Since much of mental-hygiene activity inevitably falls within the range of social action, it is essential to recognize that value judgments serve as a motivational basis for the execution of such acts.[1]

The term, "value judgment," refers to the "emergent product resulting from the weighing process an individual goes through, largely unconsciously or 'intuitively,' in 'deciding' a course of action."[2] This process becomes particularly complicated in the area of social judgment. The judgment is arrived at as a result of many factors, often largely unconscious, and it is never solely intellectual.

In contrast to these value judgments, scientific method, as traditionally defined, offers psychiatry little. If for no other reason, this would be true because of the manifest impossibility of reducing human behavior to experimental conditions, so many are the variables involved.

Lest you think me entirely naïve and committed to a rigid, formal kind of science, I should like to tell a story from my relatively dead past. When I was a medical student, I was asked in the Public Health Course to write a paper on Child Labor. In the course of my "researches," I came on what then seemed some remarkable statistics demonstrating that

[1] Adapted from a personal communication from Dr. Nathan W. Ackerman to the author.

[2] See *Understanding Man's Social Behavior*, by Hadley Cantril. Princeton, New Jersey: Office of Public Opinion Research, 1947.

the skeletal growth and weight of children working in the mines increased more rapidly than comparable age groups in English schools. From which, in my ignorance, I concluded that child labor is not so bad. I confess this for my sins and I have never forgotten the demolition of my entire contention by my professor, Dr. Haven Emerson. I have never again been so "scientific" in my approach to human beings and their problems. I imply no quest for such seemingly scientific approaches now.

The largest body of evidence on which psychiatry relies is empirical in its derivation and much of this has been learned in the course of treating neurotic patients. Although such data is clearly empirical, it has certainly been admitted to the body of scientific knowledge; indeed, without it, psychiatry would be quite barren.

Bearing in mind these conditions, I should like to turn our attention to two fields of mental-hygiene activity which, I hope, will illustrate this matter more fully. Of all the ills currently besetting man, racial and religious prejudice is clearly one of the greatest and most destructive. It is an index of this concern that an immense amount of energy and time is now devoted to the study of these phenomena of prejudice, not only by psychiatrists and psychologists, but by sociologists, historians, anthropologists, and others. Robin Williams,[1] in his remarkable survey of research on problems of ethnic, racial, and religious group relations, states that in 1945 there were 123 national organizations working in the field of race relations. His bibliography contains no less than 223 items.

In much of this research and activity, psychiatry has played a large rôle, and properly so. Wherever psychiatric research has focused itself upon the problem of the individual, both the prejudiced person and the object of prejudice, it has made significant contributions. Some of these bear directly on the interests of mental hygiene, such as the work of Brunswik and Sanford[2] on the anti-Semitic personality. Two hundred and sixteen college women and a smaller number of male

[1] *The Reduction of Intergroup Tensions*, by Robin M. Williams, Jr. New York: Social Science Research Council, 1947.

[2] "The Anti-Semitic Personality," by Brunswik and Sanford, in *Anti-Semitism*, edited by Ernst Simmel. New York: International Universities Press, 1946.

students at the University of California were studied by questionnaire and various projective techniques. The first results were similar to those found in other studies and revealed that anti-Semitism was part of a general attitude which the authors term "ethnocentrism." Furthermore, the anti-Semite tends to have a conservative political and social outlook and automatically to prefer the *status quo*.

The outstanding characteristic of the bigoted girls was the sharp cleavage between what the authors term "the overt and covert layers of the personality." "On the manifest level the anti-Semitic girls express devotion to their parents; in their thematic-apperception-test stories, the parental figures appear in a very unfavorable light. On the surface, we find emphasis on high morals, kindness, and charity . . . but there is much destructiveness in the indirect material. Likewise, there is 'official optimism' on the one hand, and fear of catastrophe on the other. There is conservatism as well as anarchy. There is the idea that everybody gets what he deserves, as well as doubt and cynicism."

In reviewing this evidence, the authors conclude that "the most outstanding feature of the anti-Semitic college women, as derived from our small sample, seems to be a restricted, narrow personality with a strict, conventional superego, to which there is complete surrender. It is the conventional superego which takes over the function of the undeveloped ego, producing a lack of individuation and a tendency to stereotyped thinking. In order to achieve harmony with the parents, with parental images, and with society as a whole, basic impulses, which are conceived of as low, destructive, and dangerous, have to be kept repressed and can find only devious expressions, as, for instance, in projections and 'moral indignation.' Thus, anti-Semitism and intolerance against out-groups generally may have an important function in keeping the personality integrated. Without these channels or outlets (if they should not be provided by society) it may be much more difficult, in some cases impossible, to keep the mental balance. Hence, the rigid and compulsive adherence to prejudices."

Or, to take another example of research soundly conceived and brilliantly executed, we may turn to Ackerman and

Jahoda's [1] studies on anti-Semitism. Accumulating data on psychoanalyzed patients from thirty psychoanalysts, the authors arrived at these, among many other, findings:

> "All the patients in their series suffered from diffuse anxiety; not one showed a sense of security in his group membership. They all had a basic feeling of rejection by the world at large, a feeling of not belonging. . . . This pervasive anxiety prevented them from forming safe and secure individual attachments. They were unhappy in their marital relations and seemed unable to maintain close friendships. They lived under a constant threat of attack on their self-esteem. Socially, economically, emotionally, sexually . . . they frequently suffered from an exaggerated sense of vulnerability. Fundamentally these people are weak, immature, passive, and dependent. In the syndrome of weakness, anxiety and instability, anti-Semitism seemed to play a functionally well-defined rôle. It is a defense against self-hate; it represents displacement of the self-destroying trends. . . . Anti-Semitism can be considered at the individual level as a profound though irrational effort to restore a crippled self."

Both these studies—and there are a good number of similarly valid ones—illustrate the solid ground that mental hygiene is on if it bases its lessons on similarly sound study. Brunswik and Sanford write:

> "To increase psychological insight and sensitivity, to bring about freedom from repression throughout the middle class is, of course, a task of tremendous proportions—hence, we should lose no time in increasing our efforts to that end. We cannot hope to psychoanalyze everybody, but education for self-understanding is something that can be tremendously expanded. We should mobilize all possible energy behind a program for increased education about man and society. If one is inclined to regard such a problem as hopelessly long-term, let him remember that education is a very durable middle-class value, and that the people's appetite for correct information is often greater than the capacity of science to supply it. It is well to remember that the kind of understanding of which we speak had steadily increased during the course of history. Less than one hundred years ago it was still the fashion in science to insist that man was fundamentally different from other animals, and less than fifty years ago many anthropologists took for granted the white man's superiority to 'primitives.' The struggle against anti-Semitism is a part of the struggle for enlightenment."

To be sure, this recommendation is, in a sense, visionary, but it is based on valid research as well as the authors' value systems and is enlightened "mental hygiene."

[1] See "Toward a Dynamic Interpretation of Anti-Semitic Attitudes," by Nathan W. Ackerman and Marie Jahoda. *American Journal of Orthopsychiatry*, Vol. 28, pp. 163–73, January, 1948.

Similarly, we may briefly mention the work on the unemployed by such students of the problem as Bakke, Lazarsfeld-Jahoda, Singer, and the present author and his colleagues.[1] These studies of the unemployed afford a detailed and well-documented picture of the emotional, social, and psychological impact of unemployment on the man and his family. The actual destructive effects of unemployment are clearly revealed; the loss of prestige and authority of the unemployed man in his family; the gradual taking over of traditionally feminine "jobs" by the man always at home; the tensions accumulating from withdrawal from the usual workday routine and its strength-providing group cohesions—these are but a few factors of obvious import to us as mental hygienists.

As long as mental hygiene bases its program essentially on such research, it has enormous merit and worth. When it uses only value systems and pronounces only that we are "on the side of the angels," I believe we have lost much of our efficacy. A psychiatrist may know much from his study of individuals on questions of political philosophy, ethics, and idealism. But I doubt that he has more to offer in these areas than other enlightened men. As a colleague recently wrote, "I think we have to be careful not to let the socially desirable, from an idealistic standpoint, coincide with our concept of the mental hygienic."

Gunnar Myrdal,[2] in discussing methods of mitigating bias in social science, states:

> "The valuations will, when driven underground, hinder observation and inference from becoming truly objective. This can be avoided only by making the valuations explicit. There is no other device for excluding biases in social sciences than to face the valuations and to introduce them as explicitly stated, specific, and sufficiently concretized value premises. If this is done, it will be possible to determine in a rational way, and openly to account for, the direction of the theoretical research.

[1] See "What Unemployment Does to People," by Sol W. Ginsburg (*American Journal of Psychiatry*, Vol. 99, pp. 439–46, November, 1942). See also *The Unemployed*, by Eli Ginzberg and associates (New York: Harper and Brothers, 1943); *The Unemployed Man*, by E. W. Bakke (London: Nisbet, 1933); *Die Arbeitslosen von Marienthal*, by M. Lazarsfeld-Jahoda and H. Zeise (*Psychologische Monograph*, No. 5, 1933); and *Unemployment and the Unemployed*, by J. Singer (New York: Chemical Publishing Company, 1940).

[2] See his *An American Dilemma* (New York: Harper and Brothers, 1944), p. 1043. The appendix (pp. 1041–1057) on "Methods of Mitigating Biases in Social Science" deserves most careful study in this connection.

> It will further be possible to cleanse the scientific workshop from concealed, but ever resurgent distorting valuations. Practical conclusions may thus be reached by rational inferences from the data and the value premises. Only in this way does social engineering, as an advanced branch of social research, become a rational discipline under full scientific control."

And, finally, I should like to quote from Dr. Alexander Leighton,[1] who has the unique advantage of being both a psychiatrist and a social scientist:

> "Emphasize the need of keeping the social scientist at work for the common good and at the same time keeping him a scientist. This means that there is need for order in the relationship of the non-scientific values with the scientific; otherwise, emotional, moral, religious, and esthetic sources of human development can be harmed by pseudo-science, while science is destroyed by the introduction of assumptions that are not part of it. . . .
>
> "The social scientist also has to mark off carefully the boundaries of his problem and within these boundaries strive to maintain the concepts, values, and methods that are part of the scientific process. . . . This means treating the social forces under consideration, not with heat and excitement, but with the same interest that would be pertinent toward molecules and ions in physiology, the animals and plants in a problem of forest ecology, the hormones and organs in medicine, and toward the human complexes and conflicts that concern psychiatry. This does not involve self-excommunication from all human feeling or carrying this attitude everywhere in life. Within the problem area, however, it does call for discipline and for an open, inquiring, non-assertive kind of mind, working with assumptions and hypotheses of varying degrees of reliability from the very first tentative to the fairly well established, but avoiding creeds.
>
> "This applies to one's own favored ideas as well as those which others may thrust upon him and urge him to adopt. He must be particularly wary of these non-scientific values with which he most sympathizes. All biases are poisonous to science, but the worst are those that appeal strongly to the scientist. This, of course, is not easy, but if there is another road to science, it has not yet been found."

I firmly believe that if we adhere to such sound principles, mental hygiene can indeed function fruitfully in many areas of social tension. There is no need for us to spin the illusion of omnipotence and omniscience.

[1] In a personal communication.

AMERICAN PARTICIPATION IN THE INTERNATIONAL CONGRESS ON MENTAL HEALTH

NINA RIDENOUR, PH.D.
Executive Officer, International Committee for Mental Hygiene

PROBABLY in future generations, as congresses come and congresses go, the wail of the organizers will take on the same plaintive refrain that runs through this report: not enough time, not enough money, not enough personnel. We were trying to do in one year a job that should have taken three, with insufficient and uncertain funds, and a tiny knot of overworked staff and executive committee, a fraction of the number we needed.

Because one often learns more from mistakes than from successes, we have set down our errors freely here, hoping that this chronicle may be of assistance to future planners. We trust that the reader will see these mistakes in proper perspective, not as evidence of inexcusable bungling, but as concomitants of a situation in which too few people undertook too big a job in too short a time.

Often during the year of organization, the going was hard. But how quickly the difficulties have faded in retrospect. At one point the American delegates were facetiously exhorted please to exhibit their best mental health while in London. They must have done so, because some weeks after the congress, the president remarked, "Isn't it interesting that no tensions were aroused that were not eventually resolved?" That is a tribute both to the British and to the Americans. Some of those earlier tensions are set forth here—for the record. But they *were* resolved.

We as Americans are proud to have carried our part in the magnificent achievement of the congress. It was superbly well organized by the British, to a degree that will inspire future organizers to envious emulation. At the congress ideas were born and accepted, and friendships were built, that will affect trans-national understanding for years to come. The two thousand people who worked together in

this country to make the congress the success that it was, and the more thousands in other countries, should be proud of their achievement. We wish to pay tribute to all of them. But, above all, to the little handful of British who labored so selflessly and so effectively through shortages and red tape and endless complications, we wish to say a strong, warm "Thank you."

The International Committee for Mental Hygiene.—The International Committee for Mental Hygiene, which had organized the First International Congress on Mental Hygiene in Washington, D. C. in 1930, and the second one in Paris in 1937, agreed to be one of the sponsors of the third congress, to be held in London in 1948. In the spring of 1947, during a visit of Dr. John R. Rees to the United States, the committee was reactivated, with Dr. Rees as president. Both the governing board and the executive committee [1] were intentionally heavily weighted with Americans; this seemed a necessary expedient. There were no funds to pay the travel expenses of members from other countries, or even from other parts of the United States. Because an enormous burden of work lay ahead, and decisions had to be reached promptly, it was essential that the group responsible for planning should be able to meet frequently. The executive committee probably had too large a proportion of psychiatrists, and another time a more careful distribution among the professions should be planned.

Actually, as it worked out later, it would have been better if the International Committee had established an American committee or division, and had drawn some line between the functions of the two committees. There was little in which the International Committee functioned internationally except in the tasks that led to the foundation of the World Federation for Mental Health. The organizing and program committees in London really performed much more

[1] The executive committee elected in May, 1947, was composed of Frank Fremont-Smith, M.D., Chairman; Molly R. Harrower, Ph.D., Vice Chairman; H. Edmund Bullis *(ex officio)*, George S. Stevenson, M.D., J. D. Griffin, M.D., Austin H. MacCormick, LL.D., and J. R. Rees, M.D. *(ex officio)*. Members added later were: Carl A. L. Binger, M.D., William H. Dunn, M.D., Lawson G. Lowrey, M.D., John A. P. Millet, M.D., Thomas A. C. Rennie, M.D., Edward A. Strecker, M.D., and S. Bernard Wortis, M.D.

of an international job than the so-called International Committee sitting in New York. Fortunately, with the World Federation soundly organized, there is not likely to be a repetition of this error.

On September 1, 1947, the present writer assumed the duties of executive officer and set up an office in space provided by The National Committee for Mental Hygiene at 1790 Broadway, New York. As time went on, the major areas of work were outlined more or less as follows:

1. Finance: Dr. George S. Stevenson, Chairman
   - Finance Committee
   - Fund-raising Committee: Miss Isabel Leighton and Mr. Arthur H. Bunker, Co-Chairmen; Miss Leona Boytel, Director of Fund-raising
   - Disbursement Committee
2. Public Relations: Dr. Carl Binger, Chairman
   - Publicity and Press Relations: Miss Alice Frankforter, Director of Publicity
   - Professional Relations
   - Invitations
     (Government groups, professional groups, organizations, etc.)
3. Transportation: Mr. H. Edmund Bullis
4. Committee on World Federation: Dr. Lawson G. Lowrey, Chairman
5. Program
   - Central Commissions
     - Children and War: Dr. David M. Levy, Chairman; Miss Helen Speyer, Executive Secretary
     - Mental Health and World Citizenship: Mr. Lyman Bryson, Chairman; Mr. Lawrence K. Frank, Executive Secretary
6. Congress Organization and Arrangements
   - Selection of Official Representatives
   - Exhibits and Films: Dr. Molly R. Harrower, in charge

The executive officer sat with all committees and directed all administration. Starting with two people in September, the administrative staff grew to fifteen by February—which was about one-third of the number really needed.

Preparatory Commissions.—The preliminary announcement of the congress, prepared in London, which described the plan of organizing multi-discipline preparatory commissions throughout the world, was distributed in the United States in the spring of 1947. As a result of this and of Dr. Rees's talks, a few preparatory commissions eagerly set to work, but prior to September of that year there was no systematic plan for stimulating the formation of commissions. One of the first acts of the executive officer was

to devise an organization plan for the entire country. Because of the shortness of time and the lack of money, the organization had to be one that would function without paid personnel and in such a way that none of its parts would be hampered in case any of them failed. It provided for a geographical division of the United States into five regions, each with a chairman appointed by the executive committee, and a division of each region into areas under the direction of a coördinator appointed by the regional chairman. Areas were loosely defined; they might consist of states, cities, university centers, or any locality in which a number of commissions were to be formed.

At the first meeting of the governing board, on September 17, 1947, there arose a tidal wave of opposition to the proposed program of the Mental Hygiene Conference *in toto*. The members present considered the conference theme and the topics of the conference program too inclusive, vague, unfocused, unlikely to produce valuable work in the United States, and certain not to enlist the financial support of foundations. Seeking a way out of this dilemma, the executive committee decided to select, as a focus for work in the United States, the topic that had seemed to arouse the greatest interest among those discussed by the board members, which was eventually phrased: "What do we do to children that leads them as adults to make war, and what can we do about it?"

The American focus was widely criticized, both here and in Europe. Space will not permit a defense of it. The reasons advanced in favor of it at the time seemed adequate. That was partly because the executive committee felt cornered by the shortness of time, and by the fact that the board refused to support them in planning for the congress around the program as presented. Probably the difficulties could have been ironed out if it had been possible for a group of Americans to sit down with a group of British and, starting with the same theme of "Mental Health and World Citizenship," to re-phrase the program in such a way as to make it more meaningful to Americans. For anything as basic to the success of a meeting as the program, it is essential to have an early and continued interchange of ideas

among the major groups responsible. If we had it to do again, we would probably not choose the focus we did, but we would be obliged to find some way out of our dilemma, and even in retrospect it is not easy to see what that should have been. Actually, the commission reports on "Children and War," and the final report of this central commission, produced some extraordinarily significant data, which should have wide ramifications in planning for the care of children who suffered from the war.

The "American focus," then, was incorporated as a "program within a program" in the statement of organization plan which was printed as a United States bulletin. The bulletin was mailed early in November, with a covering letter from the president of each organization, to the members of the American Psychiatric Association, the American Psychological Association, the American Association of Psychiatric Social Workers, and the Society for Applied Anthropology—some 11,000 professional people in all. The members of the American Orthopsychiatric Association and the Group for the Advancement of Psychiatry, most of whom were reached through the lists of the four associations named above, received a special letter urging them to take part in the stimulation and direction of commissions.

The regional and area organizations were completed in the fall.[1] Conveners of commissions began writing in to register their groups immediately after receipt of the bulletin. Application blanks for this purpose were distributed through the regional and area heads, with directions for mailing copies to the program secretary in London, the New York office, the regional chairman, and the area coördinator. These forms facilitated record-keeping in the office and impressed the commission chairmen with the importance of keeping the central office informed. As is inevitable in a voluntary organization of this kind, some of the participants did not give as much time to the work as would have been desirable; but on the whole, as the number and quality of commission reports testify, the organization worked effectively.

[1] Regional chairmen: Northeast region—Marian McBee; Southeast region—George H. Preston, M.D.; Central Northwest region—Leo H. Bartemeier, M.D.; Central Southwest region—Lewis L. Robbins, M.D.; Far West region—Martha MacDonald, M.D.

Altogether, 205 preparatory commissions were organized in the United States, including the territories of Hawaii and Puerto Rico, and 172 of these sent in final reports. The geographic distribution of the commissions was nation-wide, more dense on the Eastern seaboard and in California. New York City had more than 30 commissions; Washington, 13; Detroit, 9; and Baltimore, 7. Many chairmen wrote in their final letters that the members of their groups felt keenly the value of the association formed and the efforts started, and that they intended to continue their work. There is no doubt that many of the commissions may be counted on as nuclei of future activity.

The bulletin published by the office of the program secretary in London was reproduced by photo-offset in New York and distributed to commission members. From 3,000 to 4,000 copies of each issue were sent to commission members and other interested persons, a total of 39,000 bulletins. In addition, the executive officer sent out at frequent intervals memoranda containing information for conveners, chairmen, and coördinators.

The problem of circulating the bulletins in the United States was complicated and never satisfactorily solved according to the plan originally conceived in London. The few copies of the first bulletin issues received from London and given to the commissions operating in the early weeks were met with notable lack of enthusiasm. One reason for this seemed to be the fact that in the United States professional people are swamped with reading matter to a degree incomprehensible to Europeans; the addition of more is regarded rather as a burden than as a benefit. Throughout the preparatory period, the attitude of Americans toward the bulletins was generally one of indifference, quite in contrast with the apparent eagerness with which they were received abroad. For example, during the first several months there was only one instance of spontaneous comment from a commission chairman and a request for additional copies. This attitude inevitably resulted in the bulletins' being less effectively used here than in Europe, and detracted somewhat from the value of the bulletin plan.

One point—the procedure of the congress, especially how

commission reports were to be used—never seemed clear to many commission chairmen up to the very end, in spite of having been explained a number of times. Even as late as July, 1948, some chairmen and members of commissions gave evidence of an impression that all commission reports were to be presented individually, by a member of the commission, at the congress. Some of them worried because no member of their group could go to London and felt obligated to arrange for a substitute to read their report. It cannot be known how much this misunderstanding may have affected the morale of commissions, but it is plain now that more clear and repeated outlining of the use to be made of reports and the relation of the commissions to the congress should have been provided.

The selection of the focus topic, the impact of war on children, called for the setting up of a group to integrate the work on that subject. As commissions registered for recognition, it became plain that more of them would be working on subjects related to the congress program as a whole than on that of war and children. To handle this two-sided program, the executive committee formed two central commissions. One was the group called the Central Commission on Children and War, which worked on the American-focus topic; the other was the Central Commission on Mental Health and World Citizenship, dealing with all other topics. Reports not concerned with war and children proved to be about five-sixths of the total.

The chairmen and executive secretaries of the two central commissions conceived their task as the dual one of stimulating and directing the work of commissions and of themselves acting somewhat as preparatory commissions to produce final reports that would synthesize the most significant of the commission reports and—particularly in the case of the Central Commission on Mental Health and World Citizenship—deal with topics in the conference program not covered by commission studies. The voluminous reports submitted by the chairmen of the central commissions represent long hours of work on the part of their staffs and much discussion and consideration of tentative drafts by their members.

When the commission reports were later summarized by editorial committees, there was some evidence that some of these committees assessed the reports in terms of the professional preoccupations of the editors, which sometimes involved failure to recognize ideas and proposals not familiar or not congenial to the editors. This is mentioned in order to point out the fact that the critical evaluation of multi-discipline contributions calls for a similarly constituted editorial group. Such editorial groups should particularly be cautioned against being resistant to ideas of groups with different theoretical assumptions or coming from opposing schools of thought and practice.

Finance.—The first financial support in this country for the congress came in June, 1947, when the Josiah Macy, Jr., Foundation voted a grant of $15,000—$5,000 to be paid to the organizing committee in London and $10,000 for use in the United States toward preparation for the congress. This was perhaps too encouraging a start.

A rough estimate by the London organizing committee had set the figure probably needed for its task at $100,000, and it was agreed that the United States should supply 40 per cent of this amount, which is the percentage of United States support to the United Nations.

The first assumption of the New York planners was that a few foundations would furnish most, if not all, of the funds needed for the entire project. Before the end of 1947, however, it was plain that this was not to be so. Four foundations, one of them the personal endowing agency of a close friend of the International Committee for Mental Hygiene, had given a total of $50,000, and several major foundations had declined to consider the appeal. The budget for the whole undertaking in the United States, after a number of revisions upward, was fixed at $250,000.

In February a fund-raising director was appointed who, working energetically with a finance subcommittee of the executive committee, waged a brisk campaign for money during the next six months. The final sum raised was $158,500, of which $50,000 was sent to London. The $10,000 above the original amount pledged was our share of the support of the International Preparatory Commission. A little

less than half of the total was granted by foundations; the rest was given by more than 1,000 individual donors.

Many factors enter into the reasons why it was impossible to reach the ambitious goal of $250,000. In this country it is always difficult to raise money for non-profit undertakings in a presidential election year. Ours was a cause relatively unknown and difficult to explain to the lay public, and it was competing not only with the well-established charities, but with many post-war relief projects. Our campaign was directed by a group of professional persons who had slight experience in the technique of fund-raising, and, worst of all, it was begun too late. The wonder is that it met with the success it did. Raising $158,500 in well under a year is generally considered a creditable performance.

The year ended with a small surplus instead of a deficit because administrative expenses were cut, some functions the executive committee had hoped to perform were sacrificed, and the London organizers skillfully managed to finance the International Preparatory Commission on a much smaller amount than had been at first estimated.

Publicity.—Most Americans believe that without an expensive publicity agent, no cause can make any headway at all, and sometimes this seems to be true. The effort of the International Committee for Mental Hygiene in making the congress known to the public was at first a frustrating experience, but later it turned out amazingly well for reasons some of which had not been foreseen and some of which are still not clear.

Like the fund-raising, it was begun too late. A part-time publicity director labored throughout the winter, sending out stories on every slight pretext. The fund-raising campaign in the spring gave occasion for more news releases, but brought a discouraging amount of notice. Radio broadcasts reached a small additional audience. A few preparatory commissions got some notice in their local papers, but except for mention in professional journals and one or two articles in news magazines of national circulation, little was printed about the congress outside New York City. The congress opening found a deeply discouraged publicity director in New

York working frantically to interest newspapers, magazines, and radio networks in what was going on in London.

The day the congress opened, the situation suddenly changed. Newspapers in New York began carrying long stories by their staff writers in London and by special writers of the Associated Press. Some actually carried the opening day's story as front-page news. When the clippings from the rest of the country came in from the clipping bureau, they showed a large number of reproductions of the stories put out by the Associated Press on each day of the congress—sometimes several on one day. Papers in many cities, big and little, in 44 states printed news of the congress. During the eleven days the congress was in session, some 1,200 clippings were received. Editorials, most of them dealing with the world-peace aspect of the congress deliberations, appeared in a surprising number of papers. Many of them were original, though the most widely used were those prepared by special services and sold to papers throughout the country. A gratifyingly small percentage of the comment was unfavorable. To most of those who wrote, the congress was a signal for hope.

Of the wire services, only the Associated Press gave the congress good coverage; just one other paid any attention to the event, and its reporting was scant and poor. Most of the Associated Press stories were condensations of speeches and reports of points that would catch the fancy of headline writers and that gave little information as to the actual contribution of the material to social science. The daily press all too often distorts significant thought in this way.

The encouraging thing was that the fact of the congress was at last widely spread over the pages of our newspapers and that the points that made the greatest impression on those who described and commented on it were (1) something is being attempted by specialists in mental health toward the promotion of world peace; and (2) these specialists believe that something can be done to change the nature of man so that he can create a peaceful, rational world.

The conclusions that may be drawn from this experience are (1) that, to obtain both quantity and quality of result, a publicity campaign must be planned in advance and carried

on intensively and systematically by a technically skilled person; and (2) that the value of the institution of the publicity release in this country is open to question, because city editors seem to be considerably more impressed by what comes over the wires of the press services that they pay to report for them.

Difficulties of Trans-national Planning.—The first point to be digested by all who heard about the congress was the unconventional nature of the program. The idea of an international gathering of professional people, to be addressed, not by specialists describing their own research and presenting their conclusions from it, but by speakers whose material was to be a distillation of thinking that had been done during a preceding period by small, professionally mixed groups in the several participating countries, was new and exciting to some, but confusing to others. The inclusion of three conferences—the first two of them actually technical sessions of the memberships of two professional associations—into one congress was still another departure, and one that required endless explanation. The subject matter of the first two conferences attracted American professional people more than did the program of the Mental Hygiene Conference, and this called for further explanation.

The question of membership in the congress was even more perplexing in the United States, a cause of confusion and delay. The first announcement circulated from London in the spring of 1947 carried an application form which was chiefly a request for further information and an expression of interest in attending the congress. Although professional affiliations were to be furnished on the form, nothing was said about qualifications for membership; the word "membership" was used only in connection with the first two conferences.

It was only late in September, when the congress organizer sent to New York all the original applications received from the United States, with the request that the executive committee rate them as to eligibility for membership in the Mental Hygiene Conference, that the question of qualification came up, a question regarded with considerable misgiving by the executive committee. Members of the committee felt that,

after having sent out thousands and thousands of announcements and bulletins urging people to go to London, they could hardly thereafter point out that some of those who had decided to spend the money and time for the trip—and perhaps even had reservations—might not be allowed to attend the sessions. Both professional and lay persons in the mental-hygiene field here are used to having meetings of professional societies open to laymen who care enough to pay the admission fee; only the business and the highly technical sessions are restricted to members, and these are not publicly announced. People were reluctant to pay the rather large registration fees far in advance when they had no assurance of being admitted.

After much deliberation, the executive committee tried to meet the problem by recommending categories for membership so broad as to include practically every one likely to be sufficiently interested in the congress to go to London, but this was only a partial solution.

With the receipt and distribution of the revised application forms in January and February of 1948, confusion thickened and the New York staff aged by years. Questions poured in by letter and by telephone, some of them justified and others not. The phrasing of some of the items on the application blank was obscure to Americans. Furthermore, travel and hotel arrangements were presenting painful complications at this time because of dissatisfaction with the service offered on this side by Thomas Cook and Son, with whom the London group was dealing, and the eventual transfer of our business to the American Express Company at a late date. As this was also the period when funds were not coming in, these were harassed days in the New York office.

A factor that operated throughout the year's activities was an irrational and—as we learned later—quite unfounded fear among some of us here of the sensitivity of the British. This often placed barriers to understanding where none should have existed and caused delay because indirect methods were used where complete frankness would have expedited matters. It is sometimes said that Americans have been worrying about what the British think of them ever since the founding of Jamestown. That was borne out in our case. Dr. Brock

Chisholm tried to lay this ghost when, at one of the board meetings (late in the year, alas), he assured us that, although often our British colleagues were mystified at some of our actions, they never for a moment questioned our motives.

We had learned early in the year to have a respect amounting to awe for the superlative job of organization that Mr. Michael Harvard, congress organizer, was doing, but that was not quite the same as knowing him personally, as we came to know him later. Those who in the summer of 1947 had met Miss Sybil Clement-Brown, program secretary, had a warm feeling for her, and of course the members of the board who knew Dr. Rees had the same feeling for him, but the staff did not know him. Undoubtedly our own sensitivities were heightened because of our insecurity—for there was a period of two or three months in the middle of the winter when it looked extremely doubtful whether we would be able to fulfill our financial commitments to the British. When Dr. Rees finally visited us in May, tensions relaxed as if by magic.

One of the many lessons learned from our collaboration, aside from the requirement of time for planning, is the desirability of providing any major international undertaking with a liaison person who possesses the understanding and tact as well as the professional knowledge to smooth relations between two or more national groups. A common purpose carries groups far along the way to successful joint work. Differences in assumptions, however, often complicate communication in ways that cannot be grasped at the time. Clearly, the wrong liaison person would be worse than none. But one person who, like Dr. Rees, has the faith of all concerned and the authority as well as the ability to transmit the thinking of one group to another, is of inestimable value for smooth functioning.

Some Points to Remember.—Many of the difficulties described above were peculiar to the particular circumstances of this congress and would not recur under other circumstances. Others have already been sufficiently elaborated not to require further discussion. But perhaps a few of the snags we encountered might be examined a little more closely.

One important point to be kept in mind is the fact that the

United States, by its very size, is different from most other countries. When it comes to planning, magnitude implies not only size, but a difference in structure. One might assume that any plan suitable in a small European country could be put into effect here on a larger scale. That assumption is not necessarily correct. The plan may be entirely inappropriate for this country, and utterly impossible to carry out. The reverse is of course also true. A plan that is quite logical for this country may be inapplicable in European countries. For that reason, when nations plan together, it is essential for them to check with each other not only their basic plans, but their underlying assumptions, and such checking should take place at an early stage.

Nations have different ways of expressing themselves in words, even if they chance to use the same language. It happened with us that none of the forms printed in England were understandable here without an additional memorandum prepared here and circulated with the form. Had the form been printed in another language than ours, the chances are that it would have been sent to us in the original and we would have translated it here. Apparently the same system is desirable when the common language is English. Also, all forms with instructions need to be checked and rechecked for clarity, and then rechecked again—and then again.

The office that is later to be responsible for the follow-up must know what is going on at every stage in a project. For example, we got into difficulty when on various occasions both the London group and we ourselves issued instructions saying that such and such material was to be sent to London, without specifying that either the original or a carbon should pass through the New York office. Soon we found that we did not know what had happened and were unable to conduct the necessary follow-up. This type of error can be fairly easily avoided with a little foresight.

For the Record.—Recognizing that figures are not necessarily impressive, we nevertheless venture to repeat a few of ours for the record. Within the twelvemonth, $158,500 was raised from over 1,000 donors. Two hundred preparatory commissions were organized in 28 states, participated in by some 1,700 professional people. About 12,000 members of

professional associations were circularized, and more than 110,000 pieces of literature were distributed from the New York office, exclusive of general correspondence. Public interest was attested by the fact that 1,200 press clippings were received from 44 states within the eleven-day period of the congress.

We cannot help but wish that it were possible similarly to set down in figures the non-tangible achievements of the congress.

A Note to Posterity.—When you plan your congress, arrange for (1) more time, (2) more money, (3) more staff. However much you have, you will need more. Plan ahead—far, far ahead. Assign responsibility, but be prepared for the fact that not everybody will carry out the tasks assigned to him. Set up your machinery in such a way that no major piece of it will collapse if one person falls down on the job. Expect confusion, frustrations, exhaustion, despair. Then if your congress comes through half as well as this one, all will have been worth while.

THE PATIENT'S ATTITUDE TOWARD POLIOMYELITIS *

RICHARD H. YOUNG, M.D.

Assistant Professor of Neurology and Psychiatry, University of Nebraska College of Medicine, Omaha, Nebraska

DURING the late summer and early fall of 1946, the author of this paper and his associates cared for 41 cases of poliomyelitis. At the time of this experience, the chief interest was the treatment of the acute features of the illness. However, it was noted that for the most part the patients showed little objective fear or anxiety, and this led to a curiosity as to what their attitudes might be toward their illness and what factors might serve to shape these attitudes. The question was of considerable interest, because at the time this group of patients were being cared for, others were admitted to the hospital who evidenced great anxiety and suffered from what was thought to be a poliomyelitis, but who, upon examination, were found to be suffering not from poliomyelitis, but from a wide variety of illnesses, both organic and psychoneurotic.

One of the interesting groups was a series of five cases seen in a week, each of whom presented a psychoneurotic disorder with hysterical paralysis that simulated poliomyelitis. These cases have been reported elsewhere.[1] Also, after the acute poliomyelitis, three patients were seen who developed psychoneurotic disorders; one of them had an anxiety attack, and the other two, some time after their acute illness, came back with a transient hysterical paralysis of the lower extremities.

During the epidemic, the experience of observing individuals with anxiety who developed hysterical paralysis and, later, the observation of patients who had recovered from poliomyelitis and subsequently developed psychoneurotic features, aroused an interest in the emotional repercussions of the epidemic and of the disease.

* Acknowledgment is made to Mrs. Jean McCullough, Psychiatric Social Worker, Lutheran Hospital, Omaha, Nebraska, for her help in interviewing.

[1] See "A Clinical Syndrome Simulating Poliomyelitis," by Richard H. Young. *New England Journal of Medicine*, Vol. 236, pp. 794–95, May 22, 1947.

At the time of our initial interest in the personality factors observed in cases of poliomyelitis, we were impressed by the dearth of references on this subject. Among the 8,320 articles abstracted in the *Bibliography of Infantile Paralysis* from 1769 to 1944, a pitiful handful dealt with the personal, emotional, or psychological aspects of the disease. Recently, however, there have been references of particular interest, which will be reviewed later.

In an effort to see just what the attitudes of patients were, a group of 17 adults were questioned approximately a year after their initial illness. Of this group, 13 were female. The age range was from seventeen to thirty-seven, most of the cases being in the twenty-to-thirty-year-old group. The procedure was to interview each case with certain queries that centered around the patient's immediate reactions to the diagnosis of poliomyelitis: what attitudes he took toward his illness; what fears he might have had; what attitudes he took toward the development of muscular weakness; and what effects isolation had had upon him. Also, such matters as feelings of hopelessness and depression were investigated, and some effort was made to determine what factors had been instrumental in determining or shaping the patient's attitudes, hopes, and fears.

A second group of questions was directed toward the patients' attitudes a year later. We asked for a spontaneous expression of feelings about their illness at this time, whether they felt that it had incapacitated them, and what problems had evolved as a result of the illness.

A third group of queries was centered around the attitude of the family toward the illness and what problems were anticipated in adjustment.

Immediate Reaction to Discovery of the Nature of the Illness.—Of the group of 17 cases, only seven described their immediate reaction to the illness as one of fear, anxiety, or terror. Sample statements among this group are as follows: "I cried because of the fear and horror I had of it." A second case described herself as being frightened and excited. She felt that she had been "worn out" all summer and had entertained the fear that she might develop polio for this reason; she was not too much surprised when she did. She had the

fear that she might die or be crippled. A third case stated that her first reaction was fear. "But I seemed to get indifferent after I was in the ambulance and on the way to the hospital." This patient also expressed feelings of bewilderment. She was terrified when she became badly paralyzed in her upper extremities. She described herself as being "helpless"—"had fear because I couldn't move"; "I was so surprised"; "I was belligerent at being isolated so long."

Two of the cases who showed fear were women who were pregnant. One woman described herself as being frightened, especially by the term "polio." She felt that her delivery would be very difficult. She remembers that her thinking was rather vague, although she recalls experiencing intense fear. The second pregnant woman presented more difficulty in management than any case in the whole group. She described herself as feeling "done for." She did not think that she would live and expected to terminate her pregnancy, in as much as her delivery date was only a month and a half off. She bade her family good-bye, and said that she would never see them again. The patient now realizes how difficult her behavior was and thinks that she "was out of my head." She adds further that from the time she was admitted to the hospital until after her baby was born, she remembers being unable to move. She thought that she had a cold because of the choking feeling, and also experienced the fear that she might die.

Eleven of the patients felt that they had not been particularly frightened, anxious, or terrorized by the illness. There were three patients who thought only of the pain and distress associated with it. One of the three stated, "I think I was so miserable that I didn't have much emotional reaction." Another said that he was more concerned about the pain than about the illness itself or its results or complications. The third patient said that she just wanted them to stop the pain. While this patient had a bulbar polio, she did express panicky feelings when she found that she could not swallow, and was fearful that she might choke to death. However, most of her concern was with the pain.

One patient expressed her initial emotional reaction as one of frustration and resentment; she felt that if the disease

had been diagnosed early enough, more could have been done to stop it. A similar reaction was reported by another who said, "I was really angry. I just couldn't seem to accept the fact." This patient also expressed the fear of becoming a hopeless cripple, and referred to the suspense involved in the illness. Another described himself as being "somewhat shocked, but it didn't worry me." Several patients spoke of a feeling of hopelessness. Another thought that she had little to worry about because the doctors said the disease had been caught in time. Others expressed the feeling that they did not know what it was all about or what to expect. Those with children seemed to be more concerned about the possibility of transmitting the disease to their children than about any effect it might have upon themselves.

Other factors of interest were that those who were paralyzed in the bulbar region seemed to feel upon recovery that they were not as badly off as those whose extremities were involved. Also, it appeared that paralysis of the lower extremities was more distressing than of the upper. Most of the patients were quite hopeful with regard to improvement of the paralyzed part, and it was interesting that the nurses seemed to play the biggest rôle in shaping attitudes and hopes so far as the acute experience was concerned. The physician in charge of the case attempted to give sensible reassurances, explaining the nature of the illness and how the majority of patients are not permanently paralyzed, but it was the nurse who spent most of the time with the patient who seemed to have the greatest influence.

The effect of isolation was of some interest in that only in a few cases was there any real resentment toward the procedure. The chief concern about isolation was in the particularly terrified individuals who were badly paralyzed and badly frightened. These patients felt that the isolation was extremely harrowing. Also, with reference to reassurance, it was the patient who was not badly paralyzed who could accept reassurance best. Among the badly paralyzed, several commented that the doctor was just trying to make it easier for them.

Present Reaction to Illness.—When asked to express their present feelings toward poliomyelitis, their own experience in

particular, the main expression of feeling was that the illness is a dreadful experience. Six frankly stated that they were extremely fortunate to have done as well as they had. Most of them had a cheerful attitude about recovery of function.

The outstanding information derived from this question was the fact that 13 of the 17 cases, a year after their acute illness, still complained of weakness or fatigue. The complaint most commonly expressed was that they tired more easily. With this seemed to go a certain irritability and tenseness, but the majority showed an optimistic attitude and did not feel that they were seriously handicapped. In fact, there was no mention of being seriously handicapped.

It was of special interest that three of these patients, subsequent to the attack of poliomyelitis, developed psychoneurotic reactions. One, who had been in a ward with a bulbar case who died, about a week afterward developed an acute anxiety attack. When the nature of his illness was explained to him, he settled down and had no further difficulties. Two other patients had considerable tension and hysterical motor weakness in the lower extremities. One had a weakness in just one leg, and the other complained of a "stiffness" of both legs, which, however, was of short duration. Another patient described herself as breaking out with a purple rash whenever she was cold or became excited.

When questioned about the family's attitude toward the disease, the response was uniformly that the family was terribly upset and fearful. The patients usually described the family as having all the anxiety one would expect that they themselves might have. Some described their parents as having even more fear than they themselves had.

Anticipated Problems in Adjustment.—With regard to the problems that they felt their illness had created, they were asked whether or not a protective attitude on the part of the marital partner or the parents had developed, and whether this had seemed to carry over; also, whether the illness had created any problems in work or any difficulties in social life. Only five cases—and, as might have been expected, those who had no serious handicap—felt that their future life would not be complicated by having experienced this illness.

In 12 cases some difficulty in adjustment was present and

was anticipated. In nine of the cases some dependency had developed, but it was not causing any conscious difficulty. Most of the dependency was in terms of allowing others to assume responsibilities that involved considerable muscular effort, or in situations in which fatigue made it necessary that the patient be dependent upon some one else for assistance.

Four cases were of special interest. One arrived for the interview accompanied by her lawyer. She was contemplating a divorce and was interested in obtaining an increased amount of money for maintenance, and the lawyer felt that any medical judgment concerning her weakness and disability could be used in court. In describing her present condition, the patient remarked that, if frightened, she would feel almost paralyzed. She pointed out that when she was tired, the muscles in her legs cramped; also that the middle fingers of her right hand doubled up with a muscular rigidity.

Another patient in this group apparently had a very competitive relationship with a sister, and found it impossible to live with her mother and sister after her discharge from the hospital. She did not get along with the sister, and has now created a substitute relationship with her grandmother, aided by state payments for her dependent children. The grandmother has adopted a protective attitude, assuming the greater share of responsibility for the housework and care of the babies.

In some cases there seemed to be an attempt at denial, one patient reporting that while he was dependent on other members of the family for a considerable amount of the work on the farm, a special effort was made to help him forget the illness and his need for dependency through an avoidance of discussion.

Another patient was particularly vehement about her dependency and was resentful of the protective attitude that, she says, her family continues to take. She stated: "I would like to get completely away from every relative, and work. They don't want me out of their sight, telling me what to do as if I were a child. I resent them." She stated, also: "My mother has to dominate my plans or else she acts slighted."

During the acute stage of the illness, these patients were not questioned about their emotional or personal reactions to

the illness. The interviews carried on a year afterward were somewhat surprising in that these individuals reported very little anxiety, panic, terror, depression, or other marked reactions, but seemed during the acute phase to be more preoccupied with getting relief from pain than with anything else. They seemed to accept the motor weakness that developed as symptomatic of the acute phase of the illness, and had for the most part a hopeful attitude about recovery in the future. Only one case expressed the idea that she was going to die during the acute phase of the illness.

It was our impression that, during the acute phase of the illness, the greater part of the anxiety was displayed by parents and relatives. As a result of our inquiries, it would appear that, so far as the patient is concerned, psychological difficulties are more apt to develop after discharge from the hospital or after recovery from the acute illness. The three cases that developed psychoneurotic reactions developed them a short time after recovery from the acute illness. One case, however, had a reaction bordering on the psychotic during the acute illness.

These observations are similar to those of Meyer,[1] who states that in older children with serious paralytic involvement, "their attitudes seem characterized by the idea that they were acutely ill and that treatment was being given which would lead to a complete recovery in due time. Being all together in one open ward, they felt that they were all members of a group similarly afflicted. They saw new children constantly coming in and others being discharged as recovered."

However, the findings obtained from our interviews were somewhat at variance with those reported by Stanfield.[2] In this report, which presents a review of the literature on the personality repercussions of anterior poliomyelitis, mention is made of the unpublished work of Billings at the University of Colorado on 11 cases, describing the initial attitudes to the disease, in which Billings stated that "almost all of the patients expressed on query a feeling of shock and fear for their lives when they first learned that their disease was polio.

[1] See "The Psychological Considerations in a Group of Children With Poliomyelitis," by Edith Meyer. *Journal of Pediatrics*, Vol. 31, pp. 34–48, July, 1947.

[2] See "Personality Repercussions of Anterior Poliomyelitis," by C. E. Stanfield. *American Journal of the Medical Sciences*, Vol. 213, pp. 109–14, January, 1947.

Most reacted with depression or tearfulness, or a desire for tearfulness. Almost every one felt that most polio patients are so crippled that they are invalids for the rest of their lives."

Similar findings were reported by Ebaugh and Hoekstra.[1] A summary of their findings includes statements as follows: "The patients, when they first realized the nature of their illness, reacted uniformly with depression and anxiety." Ebaugh and Hoekstra also reported that individuals with bulbar signs in addition to the spinal type of paralysis seemed to have a greater psychological disturbance than those with only spinal involvement, and that the psychiatric disturbances developed in relationship to poliomyelitis are reversible in some degree by psychotherapy as measured by the Rorschach tests.

Reliable evaluations of the patients' immediate reactions to the diagnosis of their illness as poliomyelitis would be difficult to obtain. Personal observation and care of the patients during the acute illness would give some information, as would the retrospective inquiry into their attitudes and feelings during the acute phase of the illness. Also, the findings of the Rorschach test during the acute phase may be questioned by any one who has cared for these patients during this period. It is to be expected that the patient during this stage of poliomyelitis would mobilize a great amount of anxiety or depression; but as a result of our inquiries, it would appear that much of the affective accompaniments of the illness are repressed or screened as a defense measure and that the patient is not consciously aware of his intense feelings.

In the interviews carried out a year later, the outstanding response among these patients was the complaint of feeling tired, as well as that of being irritable. This fatigue is out of proportion to what might be expected in view of the muscle loss. Most of these cases had very little muscular disability after a year's time. The problems that had to do with adjustment within the family and toward work and society in general seemed to be very important. Some of the most disturbing

[1] See "Psychosomatic Relationships in Acute Anterior Poliomyelitis," by F. D. Ebaugh and E. S. Hoekstra. *American Journal of the Medical Sciences*, Vol. 213, pp. 115–21, January, 1947.

remarks were in the field of dependent relationships. The illness, with its threatening handicaps, would seem to necessitate a certain reorientation as to goals and to personal and emotional relationships to parents and parental figures. The inquiries would indicate that there are problems centered around sibling rivalry and competition; and implications, also, that the disability may be utilized as a punishment and that the paralysis is a symbol of inadequacy. This disturbance of body integrity causes some change in the subjective body image.

To summarize, as a result of this study, it would seem that during the acute phase of poliomyelitis, anxiety or other affective components are repressed or displaced, so that for the most part little reaches a conscious level. That there is anxiety, is indicated by the statements of some of the patients and by the Rorschach tests of Ebaugh and Hoekstra. During the epidemic, most of the anxiety is mobilized by anxious relatives and friends of the acutely ill patient. But the affect that is repressed in the patient during this acute phase may emerge during the convalescent state to complicate the personality adjustment. One of the provocative questions that arises is the basis for the generalized weakness and fatigue a year later. There is a need for more intensive study of individual patients who, after the recovery from the acute poliomyelitis, show evidence of serious problems in personal, emotional, and situational adjustment.

THE USE OF THERAPY AS AN EXPERIENCE IN GROWTH WITHIN THE STRUCTURE OF A CHILD-GUIDANCE CLINIC

MARY C. ROLAND

Psychotherapist, Tri-County Child Guidance Center, Harrisburg, Pennsylvania

BY the very nature of its structure and operation, a child-guidance clinic provides a singular medium in which unsatisfying parent-child relationships can acquire a new and different meaning. I make this statement on the premise that "a dilemma of growth"[1] is expressed in a child's behavior. A child who presents problems in his[2] psychological growth can learn, through an experience in therapy, to use this same strength in more constructive ways and to become more responsible for his own feelings. His parents, who are inevitably a part of his growth, are gradually enabled, through their part in the therapeutic experience, to free him for this forward move.

A child's behavior is a part of his life and cannot be separated from the people in it. The parents, and primarily the mother, have responsibility for directing the life of their child, and, therefore, his growth. A parent cannot do this apart from the background of her own life, so it is probable that her personal complications help to create problems for the child in his feeling of being allowed, and allowing himself, to have his own separateness from her. He is, nevertheless, a responsible and an active factor in his own life and growth, a separate person, no matter how small or how young, with inner strength that must be respected. Simultaneously he is related to others by virtue of his very existence. Since life is growth, the problems of life are problems of growth.

It develops, on this predication, that an important aspect of therapy is the extent to which it can parallel life, in being a

[1] See *Psychotherapy With Children*, by Frederick H. Allen. New York: W. W. Norton and Company, 1942.

[2] In this paper, for purposes of clarity and consistence, "he" will refer to the child, and "she" to the parent.

consciously focused experience in living. As parent and child are both individuals, each emotionally related to the other in everyday living, it is essential that each be a part of the therapeutic process. Both are coming to the clinic about problems in which they are involved together. Their interrelationship in living, which their coming evinces as unsatisfactory, can be nurtured and sustained in therapy, in the interrelated movement of this new experience. In it the therapist can help the child to feel increasing responsibility for himself as a person.

Child and parent each have their weekly hours with a separate person—child with therapist and parent with case-worker. Yet the experience is at the same time one that includes both, as parent and child come and leave together, separating for a while, but joining each other for the journey home.

Growth becomes a dilemma for a child when there is conflict between the natural impulse to grow up and the impulse to stay where he is, emotionally, or even to return to a more dependent level of existence. The conflict occurs partially because of these divergently propelling desires—to remain little or to grow up—and partially because of elements in the environment that cannot tolerate the child's being a separate person, with his own rights, decisions, and responsibilities.

This is particularly valid because the child was once, physically, a part of his mother, and the mother has a natural inclination to keep him a part of herself. Conflict arises for the child around allowing himself to grow spontaneously or continuing, with a lessened amount of guilt, as a reflection of his mother. The child is fearful of his own rights, as some one grants them or tries to take them away. From his fear of himself emerges control of others instead of responsibility for himself. The fear he develops around this process of growth turns into a determination and a struggle and fight; his strength has been used in the wrong direction and has been manifested blatantly in problems of living or problems of behavior, sometimes directly connected with the parents, often more freely and tolerably in circuitous detours expressed in relation to other people. In life he grows in relation to his parents. In therapy, he can grow and move on more satisfactorily and learn to use his strength in positive ways if the parent, in freeing herself from her child, can allow him to

move on in a relationship with the therapist. In life he is attempting to find himself. In psychotherapy, as a limited sample of life, he is offered a way of finding himself and recovering what he has lost.

When a child's behavior is such that a parent asks for outside help at a clinic, requesting—though at the same time perhaps resenting—another person's inclusion, but not intrusion, in this struggle, the parent is seeking something new, and is showing some willingness to partialize the totality and solidarity of parent and child as one person. It is a step toward breaking up a closeness that is basic to the struggle in their relationship, which the child manifests in feelings and accompanying behavior toward the parent and the other people in his life. It has made her, and hopefully her child, aware that they need help in learning to take responsibility for a new and different kind of relationship to each other.

The parent is beginning to realize that it is difficult to untie a package of emotional entanglements when she is inside it. It is likely that both parent and child, in their initial contacts, have feelings of uncertainty as to whether change is wanted or not wanted, and yet have impulses to begin on a new basis which is both desired and feared. After the application interview, the parent will know that she has a part in the clinic process in that it is necessary for her to prepare the child for coming to the clinic. Whether she can be honest and straightforward in doing this depends upon the honesty, straightforwardness, and freedom she has in dealing with her child in everyday life. Throughout the contact, we see indications of the patterns she has been habitually using with the child.

As previously stated, a parent is not using the clinic for personal therapy, to work through her own childhood conflicts. The real purpose of a child-guidance clinic is to help the parent in her relationship with her child. Although she may have to review some of her own experiences or her own parental relationships in order to move on and let her child be himself, she is there to learn to become more secure within herself as a parent, to become freer to allow her child to change, with whatever valuable by-products of change may emerge for herself or for the family constellation.

I have implied that therapy offers a relationship through

which a child can grow if both parent and child can move away from the intensity and closeness that have constricted them, to a kind of living together that can be meaningful. Through it a parent can find value in being a parent, and the child can find value in living the rôle of a child, in which he can maintain his separateness and his difference without denying it or having it denied to him.

The child comes—or, rather, is brought—to a clinic because he is having difficulty in getting along comfortably in an environment with which he is in conflict. He may be outspoken in admitting a pressing need for help and in expressing dissatisfaction with the way his life is running; he may take some responsibility for it himself, or he may blame others. He may deny any need for help and come with no symptoms, as a proof that he does not need or will not take help.

If he denies having problems, covers them up, rationalizes the uselessness or entirely evades the purpose of coming, the therapist understands that in this the child is showing the anxiety that is basic to his behavior patterns—anxiety that he can be helped to bear or to articulate. The therapist sees that the child is presenting his pattern of holding back, denying, or distorting feeling in order to avoid facing the anxiety that is obviously present, from the very fact that he expresses his feelings so indirectly. The therapist has to realize with him that even his negative self-expression has in it the expression of a strength that he can learn to use more constructively. The child may want change, yet be afraid of it and, therefore, set himself against it.

In that first therapeutic hour, and often in others that follow, he may have mobilized himself against a dangerous new situation, dangerous because he may feel it to be the carrying out of previous threats from his parents, or a situation in which he feels that he must fight to maintain himself, either reticently or aggressively, as he has had to do in his other relationships and experiences. He brings with him his feelings of distrust and apprehension, and the defenses against all his feelings which he displays to the therapist through his disguises of resentment, silence, ingratiating pleasantness, or aggression.

The therapist knows that the child brings to this hour the very conflicts that are basic to his problems, which are his

established reaction patterns. His conflicting feelings about wanting or not wanting change in himself are probably intensified by the fact that his parents have brought him because they want him to change, and, realizing this, he feels that the therapist is the person who is going to do it to him. The therapist knows that this child has been using strength inside himself, because of his need for self-defense, to help make reality more tolerable, and can help him understand that here is an opportunity for him to use this strength differently.

The child must know from the beginning that he cannot *be* changed, but can be helped, if he wishes, to change himself, and only to the extent that he wishes. He feels that he needs his defenses to prevent becoming involved with the therapist, a new person, just as he has felt it necessary, in his insecurity, to struggle against becoming involved with a family which has not succeeded in helping him feel free to grow up. But by the child's struggle, shown in symptoms, the therapist realizes, and can help the child to realize, that he can deal with his feelings directly, use his capacities constructively, and effect enough personality change to be free to be himself. In therapy the child and parent move in a situation in which the child can express his feelings, his problems in growth, his real approach to life. In therapy he shows how he attacks life. "He does to therapy what he does to life itself."[1] He brings with him in his therapeutic experience the fortifications of the past, as human beings do in new and unpredictable situations. He comes with what he has, and it is that which he brings to the therapist.

The important part of therapy is to understand the child and to let him know that he is understood. One of the most useful and helpful aspects is the experience that he can live through with an adult, the therapist, who is not a substitute for some one else, but who, in being just himself with the child, conveys to him that he is acceptable with both his good and his bad feelings.

The therapist gives him freedom to be himself without criticism, while providing, through the structure of the clinic, limitations that are not punitive. He tolerates the child's feel-

[1] See "Trends in Therapy; Inter-related Movement of Parent and Child in Therapy With Children," by Almena Dawley. *American Journal of Orthopsychiatry*, Vol. 9, pp. 748–54, October, 1939.

ings, though not necessarily all of his behavior, and gives him the experience of knowing and learning, through living and feeling, that to be asked to give up does not mean to be rejected. The child can learn in therapy that giving up is required in all living, and that as an individual he must learn to accept and to bear what cannot be changed in his life relationships. In the clinic he can live out his feelings to a reasonable extent, but he must know that the therapist, as a person, also has rights, and that limits exist in life as they exist in therapy.

The intensity of therapy does not depend on the amount of time spent with the child or on the frequency of the interviews with him. It is not necessarily defined by the severity of symptoms, but rather by the depth of feeling between child and therapist, the extent to which the child can and does use the relationship and experience as a new medium in which he can express himself, and by the growing responsibility he is able to take for his interviews, culminating in his being responsible for ending them when he feels ready for it. In this relationship he finds the therapist a person who does things not to him or for him, but *with* him. The therapist must be the steadiness around which the child's confusion and struggle, which are expressed in his behavior, can revolve in a therapeutic situation, where he can be himself and learn to live.

The child is afraid of the growth experience in real life, and he becomes fearful of it as focused in therapy; he fears the assertion that accompanies the increased awareness of self, because through it he knows he is becoming a growing and separate person, the one that he wants to be and the one that he is afraid of becoming. In therapy he can struggle to give up his old feelings and patterns, and at the same time struggle against losing them, but he must know that in maintaining them he is keeping out the new qualities and even "the present self from life."[1] The therapist's purpose is, in part, to release some of these old feelings and urges, and to strengthen those that the child has not yet been ready to use. As he grows in therapy, he finds new uses of himself.

In his contact in therapy, the child will have freedom to play, to talk, to be silent, to make his own decisions about how

[1] See *Will Therapy*, by Otto Rank. New York: Alfred A. Knopf, 1945.

he wants to use the time he is given to know is his own. Through his play, conversation, or other activity, the therapist has an opportunity to see how easily he relates to others, his patterns of sharing or withholding, inhibition or aggression, and the place he gives himself with other people as well as the place he gives them in his life. In the child's play, in his language, will be meaningful and revealing material in which he presents a combination of fantasy and reality. Through being free to express himself in play, he may move a step further, to verbalizing and bringing out more directly some of his feelings, and it is these with which the therapist can effectively deal. The child can express feeling without verbalizing, but in being articulate he really experiences a direct personal toleration of his own feelings.

The therapist constantly needs to be aware of what is happening between him and the child and not to misconstrue the *content* that the child brings to his interviews. The very fact that the child uses particular content may be revealing and significant, but the use of past material at certain relevant times is the child's way of presenting corresponding current feelings, indirectly and remotely. Past material can thus be used dynamically, as a channel for the more direct kind of expression the child needs. When he talks about what seems irrelevant, perhaps as a way of evading his real problems, the child is still producing usable material because in this very evasion he is presenting his problem.

The child may feel it necessary to talk about the past and there may be relief in it, but his growth comes, not from excavations of past events, but through what he can do as similar attitudes are revealed in the dynamic of his relationship to the therapist. He will use the therapist as he has used and does use other people, but it is the therapist's own understanding of and orientation to the basic problem that is important. He must be sensitive to the child's current feelings expressed as he employs, in the present, material from the past.

Each child will use the experience differently, as each child uses life differently. The child's relation to the therapist takes its own form and is not blocked by any particular set of rules that must be used with the child. The course of therapy cannot be planned in advance without the hazard of negating

or minimizing the spontaneous factor in it, which also characterizes growth. The therapist's base of relation to him is where the child is in his feelings when he comes—where he is and not where he was or has been. In therapy he has an opportunity to effect his own change and not have it superimposed on him, and although change may seem as if it is one more thing to fight, he can struggle with the therapist without a counter-fight in return. He can let down his defenses if he will, because here there is no reason for them, except out of his own need.

It is in the child's use of therapy that the therapist can help him define himself, for in the therapeutic situation, which symbolizes the present, he brings his use and misuse of the past. With the therapist he can bring together the old and the new, the past and the present, and, most of all, be himself, which is probably a new experience.

The ending of therapy is characterized by ambivalence, uncertainty, and anxiety, which the therapist can use with the child supportingly, relating it to the depth of feeling and the intensity that have characterized this relationship and the naturalness of being disturbed about ending something that has had so much meaning. The child needs to know that the therapist has some confidence in his capacity for being on his own and going ahead when therapy is ended. It can be affirmed for him that ending, like graduation, has in it the element of commencement, and the beginning of something new, for ending is the culmination of the new, independent self which the therapist has been helping the child to cultivate since he first began in therapy. If he can put into it intense feelings, either positive or negative, there are solid indications of his being able to put direct feelings into other things in his life without help.

Because of his newly developed independence, which brings with it feelings of isolation and loneliness in the ending phase of his therapy, he will fight growth and its concomitant feeling of power. Where he was previously fearful of what he was not, he is now fearful of what he is. But in this very struggle he assumes a new and more grown-up responsibility for himself, which can be emphasized to him as a quality that he can now begin to use in a new way. He may let his symptoms

reappear, to show that he has not changed or to give himself a respite from the grown-up qualities he is feeling and let himself be temporarily little, but, as in all growth, sliding back can be a springboard for going forward.

The child still fears growing up, but in a healthy ending to therapy he is emerging from the conflict of fearing that he is tied to childhood and yet of being forced to remain there. He can now be a part of the world without having to fight it. He and his parents should be able to live together with less tension and struggle and more freedom in relating to each other, as parent and child, with their new perspective—can function as living, dynamic persons, with enough strength, independence, and responsibility to meet situations more directly. The therapist will not anticipate the same degree of difference in every child, nor can he foresee his future needs as balanced with the effect that events may have on them, but he sees a child who has begun to separate from his old ways of doing things, and, in ending, is separating from this therapeutic experience which has paralleled life for him.

GROUP BASES FOR MENTAL HEALTH *

S. R. SLAVSON

Director of Group Therapy, Jewish Board of Guardians, New York City

THOUGH the health and integrity of the human personality, as understood in psychological terms, have been referred to in writings for many centuries, the science, and even more the practice, of mental hygiene have developed only in the last half-century. The philosophers of Greece were aware of it, and even before, in Biblical times, the question of mental health had come to attention. While in the past references to it were couched chiefly in ecclesiastical terms and philosophical terminology, more recently mental hygiene has not only increasingly come to the fore, but its practices and pronouncements are based on demonstrable fact and scientific theory.

Modern understanding of the human personality, made available to us by the medical sciences and the various schools of psychology—such as reflex, behavioristic, dynamic, gestalt, and the analytic or depth psychologies—has made us aware both of the complexity of man's psyche and of the laws of its life and function upon which health and integrity depend. We should recognize in this connection the fact that study of mental hygiene was stimulated, and its application accelerated, by the alarming prevalence of emotional disturbances and social maladjustments.

These developments are no surprise to any one who knows the basic nature of man's psyche and its ontogenetic and phylogenetic development. The more complex the material and psychologic milieu of man to which he has to adapt, the greater is the strain upon him on all levels—physical, intellectual, emotional, and social. No thinking person can overlook the fact that man's basic constitution is not adapted to the complex society that he himself has created. In funda-

* Presented at the Seventy-fifth Annual Meeting of the National Conference of Social Work, Atlantic City, New Jersey, April 20, 1948.

mental needs and cravings, man is no different from the lower animals. These needs and cravings are the drives for individual survival and for the survival of the species, as manifested in the primary hungers for food, exercise, evacuation, and sex. However, man is different from all other animals in that he has what is commonly referred to as a "soul," or the summation of all pleasure drives, ethical and æsthetic strivings, values in and criteria for living. The psyche of man is, therefore, a morass of conflicting drives and strivings. He is subjectively the battlefield of numerous and antagonistic impulses and forces. His animal cruelty is in conflict with his conscience; his hostilities are tempered by guilt; and his primitive self-centeredness is mitigated by his need for human association and group acceptance.

Perhaps the greatest of all sources of human difficulties is the dissociation of pleasure and purpose in the human psyche. In this respect man is different from all other animals and is also subject to greater inner conflict and confusion. In the lower animals, pleasure in discharging the basic survival functions, such as eating, exercise, and sex, is not dissociated from the purpose or aim of these acts. Man, on the other hand, is capable of enjoyment without the associative or consequent aims. Man eats for the pleasure of it, even after satiation. He turns the normal need for exercise into exhausting, debilitating, and even fatal sports. Combat, used by the lower animals only to gain food, achieve security, or effect procreation, in man becomes a source of special pleasures, as in participatory and spectator contests, fights, and combat.

These pleasures, detached from purpose, have attained a hegemony of their own and have become autonomous drives and appetites that frequently defeat the more imperative drives for survival of the self and the species. For example, it is not unusual for people to overeat to a point of severe and even fatal illness, or to overexert in work and sports to the point of collapse and even death. Such contradictory drives and aims constitute a grave conflict in the individual's emotional life which must be resolved if serious personality maladjustment and destructive social consequences are to be avoided. To achieve mental health, drives in the various

areas and directions must be brought into harmony in terms both of quality and of intensity, so that an adequate patterning may evolve in the individual's living and functioning in relation to his own forces and to other people.

This patterning and integration of the various drives and powers in man's psyche, so that he may function in his environment with the greatest profit to himself and to others, is the aim of the science and practice of mental hygiene. Thus, mental hygiene is not a system or a discipline apart from other formal and informal conditioning influences and institutions in our society. Rather, it is a body of knowledge and a manner of practicing already established, and common relations and experiences, both formal and informal, that condition the individual personality and the social milieu.

From the very moment of birth—nay, even in the prenatal stages—influences and pressures are exerted upon the nascent and pliable personality of the infant, to which he must needs respond and adjust. These adjustments are incorporated into his character. Inner harmony, harmony with others, and the capacity to utilize one's powers advantageously are a direct result of these formative experiences and relations. The enlightened parent, the sympathetic teacher, the professional recreationist, and the trained psychotherapist and case-worker—all know what is implied in these principles.

The aim of the present paper is to show the relationship of the principles of mental hygiene to the specific field of group work. Group work, as we employ the term here, provides informal experiences of an educational and developmental nature during the leisure time of children and adults in accordance with their maturational readiness and needs. Group work does not mean merely club work. It is rather envisaged as embracing a multiplicity of occupations and experiences to stimulate and aid the individual's self-expansion and social adaptation. Group work aims to meet individual needs for growth experiences and ego satisfactions. It enhances physical, intellectual, emotional, and social development, providing free association as well as individual self-expression in the numerous creative media evolved by man

during his centuries of striving for self-perfection and self-fulfillment.

It is our aim to attempt to integrate these two disciplines and to show how group-work practice, at its best, follows and incorporates mental-hygiene insights. On the other hand, it is equally true that any practice of mental hygiene, which is based on interpersonal relations, also incorporates to varying degrees group-work principles. By this I mean that group living in modern society is so much an inherent part of our culture that it is not possible to gain the greatest profit and satisfaction without experience of the relationships on which group-work theory and practice are based.

Before we can clearly describe this unity, some basic dynamics in interpersonal relations at the early stages of the individual's development should be pointed out. They are important because it is upon these that the educational superstructure is founded.

In modern society the infant and the child experience three distinct stages in relations, which, though quite distinct in nature, coalesce and exist in many respects contemporaneously. These periods can be described as the stages of *nurture, discipline,* and *education.*

The period of nurture occurs in early infancy, when the child lives a parasitic life, largely an extension of intrauterine existence. During this period all of his needs and wants are more or less instantaneously satisfied. His peremptory demands, conveyed or emphasized by crying and screaming, are immediately met. At this period the child is a completely dependent entity, though at the same time also autonomous. He does not submit to external discipline or routines. He does not conform to the will of others. His life energies are centered around and focused on his wants, his needs, his impulses; and these, as already indicated, are unconditionally gratified. In his behavior he is imperious, autocratic, and entirely self-centered or auto-erotic.

As he grows older and becomes ready for them, limitations are placed upon this autistic and socially unreasonable behavior. This usually begins with eating, when easy ingestion by sucking is replaced by other forms of feeding which

require effort on his part, such as taking food from a spoon and later biting and masticating it. These new feeding methods involve greater participation and exertion on the infant's part. The baby is no longer completely indulged, but is expected to exert himself in order to gain oral and gastrointestinal gratifications and to sustain himself.

As the child experiences this stage of development, he grows aware of the individualities of other persons apart from himself. This, perhaps, is the point at which the earliest identifications are established.

The transition from complete autonomy and self-centeredness to partial submission to routines and the need to exert effort ushers in the period of discipline. Habit training, which first concerns itself with food intake, turns later to anal and urethal activity. The child finds the latter controls in some ways even more difficult to accept because here he gives up part of himself to the will of another person, the nurse or the mother. Though he rebelled against giving up the nipple and eating from a spoon, it was easier for him to accept this discipline. In this situation he was receiving food; but in toilet training he gives up part of himself and his pleasures at the bidding or will of another person. The struggles that ensue and the manner in which they are dealt with by the adult often determine in large part the self-organization of the individual.

Education, the third stage, starts later in life—in our culture around the ages of five or six years, when a definite regimen begins of acquiring skills, learning facts, and being trained in social behavior.

One of the common observations in cases of young children with psychologic difficulties is either that nurture—namely, the stage of dependence and protection—was extended beyond the normal time and into the phase of discipline, or that discipline was begun too early—that is, it was substituted for nurture. Children in the first category—those in whom nurture has been extended too long—are the overprotected, infantilized, and pampered children. They present problems of maladjustment because of a weak ego structure. They are dependent, helpless, and ineffectual. Because of other external factors or of their inherent nature, they

may become unsocial or unreasonably demanding. On the other hand, children who have been controlled, disciplined, and frustrated, and whose behavior was managed and directed too early in life, develop behavior disorders of an aggressive nature. They may become destructive and disturbing, provocative and retaliatory. Such children feel themselves rejected. Many of them become withdrawn and isolated and may be found among psychoneurotics.

The importance of discipline lies in the fact that it strengthens the individual's ego, so that he can deal adequately with his drives. It prevents his becoming a victim of his own anarchic impulses and narcissistic self-indulgence; it serves to prevent false feelings of omnipotence and omniscience. Discipline by parents and teachers, therefore, is essential, but it must be so employed as to lead to self-discipline—*i.e.*, inner strength which inhibits the individual's impulses without concomitant destructive emotional consequences. This type of self-discipline is engendered, not by repression and punishment, but rather by identification and willing acceptance of the world's values because the child loves and accepts the parent, nurse, or teacher who represents these values.

That there should be a struggle between the child and the adult is inevitable. The child does not give up his autonomy willingly; he measures the strength of the adult, reacting in kind. An excitable, tempestuous, or irasible adult does not demonstrate power to the child, but rather renders his ego weak, unstable, and incapable of dealing with difficulties, conflicts, and frustrations. The easy-going, patient, reasonable reaction of the adult, on the other hand, builds like patterns in the child. Through his own reaction, the adult demonstrates ways of dealing with life, but what is even more important is that through such attitudes he harmonizes the child's personality and strengthens it. It is commonly accepted that the child's superego—understanding of right and wrong and awareness of guilt—are established through the imposition of the authority of the parents. But we must recognize that they are responsible for his ego development as well.

The structural relation between discipline and repression is a very close one, and some emotionally charged drives

must be appropriately repressed if the individual is to make an adequate adjustment in life. But repressions must be established without violence to these drives and to their peripheral or associated emotions. It is one thing to make an individual moral and responsible; it is another to render him, in the process, emotionally frigid or compulsively anxious. Repression and discipline are first established through parental controls, but this is only the beginning. An individual cannot flourish to the fullness of his potentialities, or establish the necessary integration in his personality, through these primary relations alone.

In the development of the individual in our culture other relationships are almost as important. Certainly no individual is adequately adjusted who has not established meaningful contacts with people and groups outside of the home. At the age of six or seven, after the termination of the Œdipal conflict, the psychic energies are dislodged to varying degrees from the persons in the family and directed to people outside the family group. Free association in play and work are of the utmost importance at this stage. The child now enters on a new path which leads him from the limited circle of the home toward the larger world and new and expanding experiences. To do this adequately, he has to repress some very important impulses and cravings he has had toward members of the family, especially his parents; to redirect some of these impulses to persons outside the home and to evolve new needs, the most important of which is the need of associations and friends. This we designate as *social hunger*.

Some of the extra-familial associations are casual playmates, nursery and kindergarten groups, classmates and later social clubs, occupational groups, and finally one's own mate and children. The experiences that ensue from these associations are absorbed into the structure of the personality. The ego, the group superego, and the various defenses that had their beginnings in the family relations are furthered in their growth, modified, and brought to a state of more or less final formation through group associations.

Man is nothing without the work of man and that which is human in us is the result of experiences with other humans.

The aim of a good education is to make these experiences with people health-producing and strengthening, rather than weakening and disorganizing, as is only too often the case. Play on the streets is not infrequently a tragic or, at least, an emotionally debilitating experience for many urban children. Nurseries, when at all available, are by and large repressive, inhibiting, and rigid. Infants are confined to play pens, their movements are restricted or impeded, and spontaneity is punished. Kindergartens, with few exceptions, present a similar picture. The occupations provided counter the psycho-organic drives and needs for free movement and pleasant play. Work with small muscles is imposed when growth needs would be best met through free, spontaneous play and work involving large muscles. The requirements for concentration involving eye and hand and postural rigidity are beyond the child's readiness and capacity.

Here, as well as in later school classes, intellectual effort is imposed prematurely, and emphasis upon reasoning and memorizing are misplaced in the sequence of the orderly and healthy development of the child. The result is a very much disordered individual, with many anxieties and fears lest he fail to make the grade and be accepted by his own child world, the school. These anxieties are very real and very threatening, and most of the children who are brought to clinics and social-service agencies are there because of this anachronous type of education, so thoroughly inconsistent with the basic laws of child development and the requirements of mental health.

Most modern textbooks in psychology list the various mechanisms through which one adapts one's self to inner and to outer realities. The most important of these are repression and sublimation.

Repression is the most common tool that individuals and groups in power use against those who are subordinated to them—parent against child, the older against the younger, police against citizen, rulers against the ruled. It is the democratic concept of human relationships that has to some extent led to the discarding of repressive practices and helped to bring forward liberalizing attitudes, values, and techniques in home life, schooling, and social living. But when these

external controls are removed or considerably reduced, other means for dealing with primitive and unmoral instincts are necessary, for there is real danger in the unbridled and uncontrolled expression or acting out of instincts and impulses.

Here we must reckon with the animal sources of man's primary needs and drives. Being what they are, they need modification and refinement, if you will, in order to render each safe for the others in the immediate or wider community. Mental hygiene tells us that while we need to refine instinctive drives, this cannot be achieved entirely by repression, but rather by removing the edge of the harshness and cruelty inherent in them and by finding appropriate sublimations for them. While some impulses or instincts must be repressed—and the more successful the repression is, the better—others need only partial repression; and for some sublimations are most effective.

If we return again to the three major stages in development outlined, we find that in the stage of nurture, no repression or sublimation is demanded from the child. He can and does act out his primary impulses. When discipline becomes necessary, it consists of the repression of some impulses and the provision of sublimations for others. During the period of schooling, on the other hand, we require the child to submit to routines that, in very important respects, are really frustrations. We require him to inhibit basic drives for neuro-muscular and vaso-motor activity. We require of him an extensive and concentrated use of some of his organs that are maturationally unready for it. One classical example is learning to read early in life, which involves concentration of the eye muscles and the translation of visual into ideational and vocal symbols; another is learning meaningless historical events. All of this means frustration for the more primary biological needs for play and free expression.

As understood in mental hygiene, education should rather supply, in as many respects as possible, support and help in sublimation rather than repression, and should emphasize the disciplinary period of early childhood. At the present time, schools ally themselves with the suppressive values of

the superego, the social *mores,* and the executive functions of the individual's ego. Rational education, however, which takes cognizance of the laws of mental health and the nature of man, seeks to provide adequate expression to impulses that are acceptable to the group, and provides sublimations for those that in their raw form are intolerable to the group. While present-day schools are by and large repressive and do not conform to the laws of mental health, the education of the future, it is to be hoped, will change its practices to conform with the better understanding of individual and group needs.

This possibility has been demonstrated in the last three decades by the so-called progressive schools. Some indications of changes in the same direction are discernible in some of the more enlightened public schools as well. This is seen in provisions for play periods alternating with classwork, modifications in rigid marks and report cards, curricula and activities to satisfy the more primary activity needs of children, and greater social awareness as against purely intellectual aims. These forward-looking changes, however, are as slight as they are rare, and it is to be hoped that more will be done for our schools in this direction if we are to make democratic principles articulate and applicable.

As against the fairly grim picture that one sees in contemporary schooling, the group worker stands out as a ray of hope. He provides the child with play and activities. He emphasizes the importance of evocative and expressive activity which parents and teachers are not usually equipped to promote. Being free from curricular restrictions and rigid requirements such as prevail in schools, he can provide opportunities for creative expression both in program activities and in free social intercourse. The significance of this has already been indicated in preceding pages, for it is an accepted axiom that successful human adjustment in our society involves the ability to establish adequate and satisfactory relationships with others. Experience in such relationships is not ordinarily provided either in the home or in the school, and group workers here play a very important rôle in the mental health of participants.

Group work also supplies opportunities for sublimation of the many socially unacceptable unconscious drives and cravings, both through program activities and through desirable identifications and group relationships. The transition from the self-centered child to the more inclusive social personality are aided by the type of setting group workers provide.

Of particular importance in this connection is group work during adolescence. In this stage of transition from childhood to adulthood, from dependence to independence, the support that adolescents can give one another is of great importance. This is manifested and is observable in the spontaneous groupings that young people develop at this age. Group workers provide a constructive and wholesome environment in which these important relationships can be developed; but what is of even greater value is that they canalize them toward socially desirable aims and purposes. Group workers can, and in many instances do, lay the foundation for useful citizenship which is so essential to a satisfying personal adjustment.

The significance of group work for wholesome personality development at all ages lies in the fact that in the group-work setting the individual finds the milieu in which he is fully accepted for what he is and can function on whatever level of development and capacity he may have reached. The competitive element should be reduced here as far as possible, so that anxieties aroused by the fear of failure, and awareness of real or fancied inferiorities, may be minimized or eliminated.

Because group-work programs are not set and rigidly imposed, participants are not in a state of fear as to their success or failure. A relaxed feeling is thus engendered and the tensions so characteristic of schools and industry are absent. As a result of this comfortable feeling, an optimistic and hopeful outlook emerges. Feelings of self-esteem and self-worth are greatly enhanced and many individuals who believed themselves failures in other relationships, grow convinced of their value, their abilities, and their strengths.

Group workers recognize that the major need of the child is not learning, but growth. They provide opportunities

for maturing. They help each child to grow at his own pace and in a direction most suitable to his constitutional needs and acquired preferences. This convinces the child that he is accepted and loved and in turn gives him a feeling of security. The security that the child receives from an understanding and sympathetic adult is the very foundation of mental health.

Such an approach to the educational process does not emphasize innate or conditioned handicaps or backwardness. The child who may not be expert at arithmetic may be a good carpenter and thereby attain status in the group. It is this positive acceptance, which is capitalized in strengthening the personality, that is emphasized by the group worker.

Group workers can adequately meet the needs for self-assurance and for self-expression that are essential to development. They can establish attitudes of self-esteem, satisfy the drives to mastery, serve the desire for admiration and recognition, encourage the exploratory impulse to investigate and discover. A proper group-work setting and program can help individuals to find their genuine interests in life, and in many instances even serve the needs of vocational guidance.

Elsewhere I have said that "the four major contributions of the good family, and of all group education, are: (1) to establish satisfying affective (love) relations with children and with adults; (2) to provide ego satisfactions; (3) to give expression to the creative-dynamic drives of the individual; and (4) to engender emotions and to establish attitudes that dispose the individual to social usefulness and group participation. These are at once the objectives and criteria for evaluating good group work."[1]

The maximal program of mental hygiene has social aims as well. Inherent in mental hygiene is the preservation and the extension of democracy for the total community and the world at large. When the group worker encourages small groups and clubs to conduct themselves democratically and helps the members to participate not only in these groups, but also in the neighborhood center or settlement in which

[1] See *Creative Group Education*, by S. R. Slavson. New York: Association Press, 1937.

they meet, he is following the basic precepts of mental hygiene. Mental hygienists, as well as group workers, insist that the democratic plan should not be limited to these groups or centers, but that it must be extended beyond—to the community, to the nation, and to the world.

Developing a sense of responsibility, which is the major indication of maturity, and sharing the work of the world are part and parcel of group-work aims. Despite the fact that the young child may at first resist responsibility (because he resists growing up and carrying the burden of maturity), the group situation takes him out of this state of inertia and places him in a relationship in which he unavoidably assumes responsibilities. The result is not only a growing sense of responsibility, but also of self-reliance and self-determination for social ends.

One constantly meets adults who are more aware of and more responsive to social problems and needs in our times and who have a better understanding of these than the average. It is encouraging to discover in conversation with them that the motivation for this development and interest were derived from the stimulation of leisure-time groups and their inspired leaders. Upon further consideration, one finds that these groups have freed them for intellectual search and free exploration. They have been sensitized to the world around them and have been stimulated to take an active part in it.

THE EFFECT ON CHARACTER DEVELOPMENT OF PROLONGED OR FREQUENT ABSENCE OF PARENTS

MORRIS D. RIEMER, M.D.
Brooklyn, New York

OF a common occurrence in the history of nervous patients is the fact that one parent was "not at home" for a long interval of time, was frequently away, or was not seen at all by the child for many weeks on end. This parent is usually the father when the staying away is to earn a living, when the business is out of town, or when there is the need to go to war. Other causes for the absence are repeated bouts of illness that require changes of climate or hospital confinement. Marital discord, separation, and divorce are responsible for the parents' remaining away more consistently. Death of a father or of a mother necessarily involves complete loss of the security provided by that parent unless there is a foster parent.

These instances cover in general the factors most commonly met with to account for the physical absence of the parents. According to the facts to be presented, they are responsible for a great many developmental character difficulties in the child. Of still greater consequence, however, are those situations in which the parents are physically present, but a prevailing lack of emotional responsiveness makes them even more dangerously absent. The most traumatic familial background involves a combination of both the physical and the emotional absence of parents.

Typical examples are the following:

One young lady speaks of seeing her father, as far back as she can remember, only on week-ends, because his business, which was in an adjoining state, occupied most of his time. A second patient's father, a physician, left his daughter at the age of five to come to the United States. It was impossible for him, on account of the quota requirements, to get his family to this country until six years later, when the daughter

was eleven years old. A third individual tells of meeting his father only about once a month on a Sunday. His father came home from work when he, the patient, was asleep, and in the morning, when he awoke, his father had already left.

Invariably, such persons feel particularly "estranged" from the absent parent. The very circumstance of the physical absence of the father creates a lack of intimacy between parent and child, most painful feelings of being neglected, with resultant anger and fear. The latter emotions are disturbing and must, therefore, be repressed. Evidence of such strong emotional repression is the fact that these individuals cannot remember much about their childhood. During treatment, however, these feelings are encouraged to come into consciousness and are then clearly expressed.

The marked increase in delinquency and the greater incidence of behavior difficulties in children during and immediately following the war years are clear-cut coincidences and, therefore, probably consequences of the absence of fathers who were in the war. Where the remaining parent, the mother, worked in a defense plant or was "away" because of some other occupation, the affected child's problems were all the greater.

These findings—the symptomatology, the incessant insecurity, and the estrangement or detachment of such individuals—tell all too well the trauma resulting from the absence of the father. A glimpse into the clinical picture of the illness that supervenes helps trace the effect of the damage induced by the absence of the parent.

The first young lady, who met her father only on week-ends, developed a severe contrariness as a child—refused to eat and almost starved to death. At the time of her marriage at nineteen, she began to suffer from agoraphobia, a deep anxiety at being alone, and a fear of dying from a sudden heart attack. She often felt quite helpless and discouraged and had great difficulty in expressing her thoughts because she believed that every one would consider her stupid.

The next patient, who missed her father from the age of five to eleven, likewise developed, soon after her marriage, a severe agoraphobia with the characteristic fear of being left alone. Because of her underlying panicky feelings, she

was constantly compelled to distract herself in every way to allay her fears. She also felt that she was very inferior and stupid.

The third patient became a seclusive, shy young man who kept to himself and would become manifestly nauseated on meeting strangers. He entertained a strongly misanthropic set of ideas with an accompanying crippling skepticism of people and their actions.

These three patients showed prominent infantilism in their characters. They spent most of their time in magical reveries consisting of wish-fulfilling, absurd daydreams. There was, therefore, a pronounced withdrawal from reality and from contact with other human beings. Each of these persons had a feeling of "being alone." Another reaction to this early separation from the parent is a distressing misgiving of "not being wanted or of being undeserving." These convictions were present in all three patients and constituted the major part of their insecurity. During treatment, these patients elaborated upon their suppressed feelings of suffering as a result of their inability to "reach" the parent during their early, needy years. They dwelt consistently on the submerged hostility and fear of their elders who remained, so to speak, "strangers" to them.

The inability to effect adequate contact with the parents during childhood necessarily impairs every ensuing human relationship. The child, over the many years of parental deprivation, develops a protective pattern of automatic withdrawal from which he cannot free himself. The absence of parental affection and contact diminishes the vital nourishment that the helpless child requires for his character growth. The behavior difficulties and the neuroses that follow become expressions of the immature character's attempt to cope with the responsibilities thrust upon him.

When the absent parent is the mother, the trauma to the character is much greater. This can be observed regularly in the handling of psychic disturbances in which there is a history of the death or prolonged absence, through sickness or separation, of the mother during the early childhood of the patient. The increased crippling of the character seems to take place because the mother plays a much greater rôle

in the rearing of the child in our society. The presence of the father alone entails only partial physical and emotional contact at best, since this parent must remain away from home the greater part of the day as the "breadwinner."

Careful search for the effect of the absence of one or both parents will disclose that the degree of immaturity of the character is in direct proportion to the total amount of withdrawal of the parents. Death, long physical illness, the separation or divorce of parents involve a much more serious absence. Parents who are criminals, psychotics, alcoholics, drug addicts, or very inadequate are "absent" emotionally. They have but little, if any, positive feelings to offer their offspring. With such parents, the child is reared almost as if "in a vacuum," without any reassuring or security-giving support from his home environment. Such a familial set-up becomes more complicated and more frustrating when even the "non-giving" parent disappears through death. The latter status frequently forms the background of the worst mental disorders.

Clinical histories regularly furnish evidence of such tragic home conditions. A young lady, a brilliant authoress, comes for treatment because she feels that she is ugly and is unable to sleep, worrying over her graying hair. The patient is actually good looking and excellently endowed in intellect. She is, nevertheless, plagued by her delusional ideas of inferiority, which take the form of convictions of ineptitude and ugliness. These ideas absorb most of her time. She has no desires for the opposite sex and feels undeserving of any pleasures.

The childhood history reveals that the patient's father did not talk to her except on rare occasions, when he berated her unmercifully. He died when the patient was thirteen. The mother is undemonstrative, anxious, interfering, and extremely morbid. In this patient there is severe, perhaps irreparable character pathology, which is directly proportional to the overwhelming emotional withdrawal of the parents.

From a logical standpoint, it would appear that these findings might in themselves be self-evident. Confirmation from clinical material is obtained invariably if one but takes the trouble to investigate the parental milieu. Yet these simple

facts seem quite frequently to be overlooked. There is a tendency to attribute the impaired character development to other causes, such as heredity, educational background, or physical or chemical bodily changes, or even to blame the patient himself for his difficulties. This blindness to our own doings as parents may very well be an escape from guilt feelings induced in a substantial percentage of society in which marital discord is prevalent. A casual glance at the high divorce rate is a good indication of this state of affairs.

Insight into these parental influences is essential for any prophylactic or remedial endeavor. Successful therapy for the immaturities in character formation involves giving to the patient, through "the transference," that which he did not get from his parent. Such therapy could very well be instituted in greater measure at the very outset of childhood by a mental-hygiene program that can evolve a method of reaching and informing more parents of their responsibilities.

Forced physical separation of a parent from a child, whether due to the economic situation, to health, to accident, or to war, deprives the child during a vital developmental period of the nurturing "influences" of one parent. The other parent, overburdened by the undue and greater responsibility, cannot be sufficiently free, under such duress, to "give her all" to the child. The latter phenomenon is multiplied in its damaging influences when the parents are "emotionally absent."

To summarize:

1. Prolonged or repeated physical absence of one parent creates a poor environmental soil for the growth of the child's character.

2. Severely neurotic, psychotic, criminal, or maladjusted parents are emotionally absent and create a milieu that is devoid of nourishing influences for the child's character development.

3. The distortion or maldevelopment of the child's character is usually in proportion to the sum total of "physical and emotional absence" on the part of the parents.

4. A large percentage of our population—probably more than 50 per cent—are unaware of the influence on character growth of a positive physical and emotional parental presence.

JAMES ROWLAND ANGELL

Dr. James Rowland Angell, President Emeritus of Yale University, died on March 4 at his home in Hamden, Connecticut, near New Haven. He had been president of Yale through the sixteen years of its period of greatest expansion, from 1921–1937, after breaking a two-hundred-year-old tradition by becoming the first Yale president who was not a Yale graduate.

Dr. Angell brought to the university an international reputation both as psychologist and as educator. He was born in Burlington, Vermont, on May 8, 1869. His father, James Burrill Angell, was at that time president of the University of Vermont, later becoming president of the University of Michigan, which his son entered at the age of seventeen.

After graduation, Dr. Angell studied at Harvard under John Dewey and William James, and then went abroad to work at Halle, Berlin, Leipzig, Vienna, and Paris. Upon his return in 1893, he went to the University of Minnesota, as instructor in philosophy, and the next year to the University of Chicago, as assistant professor of psychology and director of the psychological laboratory. He was associated with that university for twenty-five years, becoming head of the department of psychology in 1905, and dean of the university faculties in 1911, and serving as acting president of the university in 1918 and 1919.

From 1920 until he went to Yale in 1921, he was president of the Carnegie Corporation.

In selecting Dr. Angell from among several educators for the presidency of Yale, the university corporation stated that the choice had been made in the belief "that no one in America combines more breadth of education experience and business ability, high public service and spiritual ideals than Dr. Angell." His achievements at Yale are too well known to need mention here, nor would it be possible to do justice to them in the space available. Of greatest interest, probably, from the point of view of mental hygiene, was the establishment of the Yale Institute of Human Relations, which Dr.

Angell aimed to make a modern center for the treatment of mental illness and for training and research.

Upon his retirement from the presidency of Yale in 1937, at the statutory age of sixty-eight, Dr. Angell had richly earned a period of leisure, but he was too active and too much interested in his chosen field to give up work. He became educational counselor of the National Broadcasting Company, with which he was associated until his death.

Dr. Angell's interest in mental hygiene was lifelong. He early identified himself with The National Committee for Mental Hygiene and was extremely active in its work. At the time of his death he had been one of its vice presidents for twenty-five years. He attended a meeting of its board of directors as late as last January. His advice was constantly sought and was invariably found wise, creative, and forward-looking.

Surviving are his widow and a son and daughter by his first wife—Mrs. William Rockefeller McAlpin, of New York City, and Professor James Waterhouse Angell, of the Columbia University Economics Department. He also leaves a stepson and four stepdaughters—Stuart Woodman, of New Haven; the Misses Caroline and Katherine Woodman, both of New Haven; Mrs. Charles Hendel, of Midland, Texas; and Mrs. William Ford, of Salisbury.

Dr. Angell's passing deprives us of a great leader in education, philosophy, and psychology, as well as in the whole field of mental health. He will long be remembered by the staff and directors of The National Committee for Mental Hygiene, and the inspiration of his counsel and of his constant encouragement will continue to be a guide and a help to us as our work progresses.

ARTHUR H. RUGGLES

BOOK REVIEWS

THE COMMONSENSE PSYCHIATRY OF DR. ADOLF MEYER. Edited by Alfred Lief. New York: McGraw-Hill Book Company, 1948. 636 p.

This is a handsome volume, beautifully illustrated, dealing with the professional life of Adolf Meyer, emeritus professor of psychiatry at Johns Hopkins University. It is written by a professional biographer who became interested in Dr. Meyer and his writings as a consequence of a continuing effort at "postgraduate education in life," which led him to seek "clarity on the subject of psychiatry." Finding no book at hand that dealt with the growth and development of Dr. Meyer's concepts, Mr. Lief decided to go to the source of those concepts and write his own book. The present volume is the result, and a first-rate job it is.

In reporting on the volume, it has seemed to this reviewer that two aspects of the book must be covered: first, its content, which in this case is, as the author states, composed of fifty-two selected papers from Dr. Meyer's large collection of publications, with biographical narratives supplied by the author; and second, the actual job of reporting as done by the author.

To take these items up in reverse order, I have it on the explicit statement of the author that he had completely free access to all of Dr. Meyer's published material, and—what is more important from the standpoint of the reporting job—he had completely free choice, and apparently exercised it freely, in the selection of the papers to be included in this volume. As an old student of Dr. Meyer's, who also has read virtually everything he ever wrote, it appeared to me amazing that Mr. Lief, out of his own approach to the matter, should have chosen for inclusion the very same documents that I myself had found most inspiring and significant in gaining a view of the nature and intrinsic merit of Dr. Meyer's contribution toward the development of genetic-dynamic psychiatry.

To name only a few, which all students who trained seriously under Dr. Meyer will recognize instantly for their importance, we find the following: *The Biological Approach to Psychiatry* (1897); *An Attempt at Analysis of the Neurotic Constitution* (1903); *Emotion and Intellect in Paranoia* (1906); *Fundamental Conceptions of Dementia Præcox* (1906); *Misconceptions at the Bottom of the "Hopelessness" of All Psychology (Mobius)* (1907); *The Problems of Mental Reaction Types, Mental Causes and Diseases* (1908);

A Discussion of Some Fundamental Issues in Freud's Psychoanalysis (1909); *The Problem of the State in the Care of the Insane* (1909); *Conditions For A Home of Psychology in the Medical Curriculum* (1912); *Objective Psychology or Psychobiology, with Subordination of the Medically Useless Contrast of Mental and Physical* (1915); *The Life-Chart* (1919); *Normal and Abnormal Repression* (1922); *Freedom and Discipline* (1929); *Preparation For Psychiatry* (1933); *Spontaneity* (1933); *The Birth and Development of the Mental Hygiene Movement* (1934); *Respect of Self and Others and Equity for Peace* (1943).

Since the volume is concerned solely with Dr. Meyer's psychiatric contributions, it does not include a large number of extraordinarily interesting and important neurological contributions from his earlier years, and his famous paper on construction of the brain model, published with Louis Hausman.

From this small selection from the group that Mr. Lief culled for his book, one immediately gets a life-chart view of Dr. Meyer's own development, starting with highly technical matters, dealing with diagnosis and treatment, with a shift of emphasis as time went on to training problems, organization of psychiatric care, and social and even political implications. When to this excellent selection of papers is added the fact that the author has done a splendid editing job, condensing the contents of several papers into one chapter, for instance, tying it all in with the actual circumstances of Dr. Meyer's life and work, a very effective, even dramatic, statement is made, showing the man in action, in a way that pleased Dr. Meyer's sense for the significance of history and biography.

Using his subject's own words and illustrating the point on occasion after occasion, Mr. Lief points out Dr. Meyer's lifelong devotion to "the whole of man, not just the parts." Furthermore, he expressed this devotion not in rebellious, revolutionary efforts, featuring bitterness or personal ambition or any desire for reward beyond the expanding opportunity to spread the gospel of relevance for the individual and society, for the better understanding of the individual in his society; working always within the framework of the established order, but working toward a compromising of factional differences and toward the realization of that agreed-upon common sense which would be based not on hunches and appeals to the mystical, but upon the specificity of items for study.

The author quotes Dr. Meyer as describing himself as a "meliorist—neither an optimist nor a pessimist," but as one who worked always toward the betterment of conditions. Even here, he had reservations, as, for example, "We do not want to make the better the enemy of the good, but to help promotion of the better." His whole tendency

was to seek to objectify life, and characteristically he adds, "It is something I would recommend if it can be kept free of making itself a pest to the self and to others."

I started out to cover the two aspects of the book separately, but I see that I have ended by covering them jointly, which is a tribute, as far as this reviewer is concerned, to the author's expert job in culling from Dr. Meyer's writings the real essence and presenting it in a way that is telling and dramatic both as biography and as professional contribution. As far as the actual content is concerned, there will be many people who will say, as they have been saying for years, that these contributions are important, but dated and no longer pertinent to the main body of psychiatric thought, which they will have no hesitancy in identifying as psychoanalytic. To take a leaf from Dr. Meyer's own book and eschew controversy as not very profitable, it may be well to admit, with the subject of this biography, that the material has no glamour, no appeal to the esoteric, and because of these very facts, will attract to its standard only certain kinds of adherent. Nevertheless, the faithful reading of the material of this book will reward the critical and open-minded reader with a broad viewpoint, which transcends doctrinal methods and doctrinal enthusiasms, and earns for it what this reviewer would consider the highest compliment, although to others it will appear wholly derogatory—namely, that it offers a sound, workable, practical philosophy of living, both for the well and for the sick, with no limit to the opportunity for the application of special methods and special viewpoints to special problems.

If any one wants to measure the Meyerian influence, let him consider the status of psychiatry in America when Adolf Meyer came to the United States and then its status as he stepped down from his chair at the Johns Hopkins University. To this reviewer, it appears that his search for the commonly accepted facts—which he called the facts of critical common sense—is very much the order of the day, and when one sees the diverse methods that are used in our field, the plethora of theory and the paucity of actual well-established facts, we can only thank him for stressing throughout his lifetime the urgency of the need for this search.

There are several illustrations dealing with Adolf Meyer's early years in Switzerland and in America, and it is wholly fitting that the author picked for a frontispiece the photograph of Dr. Meyer from his happy period at Johns Hopkins Hospital.

This volume should serve as an exceedingly useful reference work for medical students, practitioners, sociologists, and others and should serve also to whet an appetite for Dr. Meyer's collected papers, which are to be published by the Johns Hopkins University Press.

In passing, it may not be out of place to mention the quotation, in Mr. Lief's preface, of a reference by Dr. Meyer to the author of a certain textbook as "washing his hands of the subject." The book so referred to is not further identified, and since there are not many books dealing with Dr. Meyer's conceptions, it is certainly within the range of possibility that the reviewer's own textbook is meant. But however that may be, my judgment of Dr. Meyer's work, as expressed above, would still stand. Furthermore, I would be in practical agreement with the implication in the comment quoted that no book has done him justice, for the simple reason that he was head and shoulders above his contemporaries and his pupils in the breadth of his thought, much as Freud towered above his contemporaries and pupils. No one can speak today authoritatively as to Adolf Meyer's views on any problem, psychiatric or social. No better statement is to be found than in his own published works, and while his statements at times seem enigmatic, those of us who were in closest contact with him gained a certain skill in interpreting them. Furthermore, it is true that his followers not infrequently washed their hands of psychobiology, and this was due directly to an intrinsic feature of Adolf Meyer's own personality—namely, his constant urging toward a better performance on the part of all those about him without specification of the methods to be used in reaching goals or even of the goals to be reached, leaving all this to the initiative of the participants. He expected each one of his students to discover his own special interests and to devise his own method of work within the general framework of the scientific method; and not too many people prospered under this liberal, yet exacting system.

WENDELL MUNCIE.

Baltimore, Maryland.

THE MENTALLY ILL IN AMERICA. By Albert Deutsch. Second edition. New York: Columbia University Press, 1949. 555 p.

When the first edition of this book appeared in 1937, it constituted a landmark in the history of psychiatry. Here, for the first time, was a thorough and scholarly study of the evolution of the care of the mentally ill in this country, from the days of "bidding off" the luckless patient to the establishment of our present hospital system. The book has been in steady demand, with a third printing necessary as recently as 1945.

Since 1937, however, much has happened. A war has come and gone, the scope and concepts of psychiatry have vastly increased, and many of our institutions, thanks to a combination of circumstances, have deteriorated in standards and undergone even more crowding than was the case before the war.

Mr. Deutsch has continued his interest in the subject to which he devoted himself twelve years ago, and now has given us a revised second edition. He has added a new chapter on "Psychiatry in World War II," and has taken appropriate cognizance of the developments in hospital care and in psychiatric treatment.

In view of the growing public interest in psychiatry and the obligations of the community to the victims of mental disorder, there can be no doubt of the wide and urgent demand that the appearance of this volume fills.

WINFRED OVERHOLSER.

St. Elizabeths Hospital, Washington, D.C.

THE ALCOHOLIC WOMAN. By Benjamin Karpman, M.D. Washington, D.C.: The Linacre Press, 1948. 241 p.

Alcoholism has been termed "the greatest unsolved public-health problem." It has been estimated that from two to three million men and women in this country fall into the classification of intemperate or chronic alcoholics. Since the intemperate use of alcohol brings in its wake misery to the individual and to his family and eventually leads to mental deterioration, delinquency, and social dependency, the problem of alcoholism concerns the whole community.

Despite the gravity and universality of this problem, no general preventive program has as yet been formulated. There are few hospitals available for the care and treatment of alcoholics, few centers of research. In some communities attempts have been made to meet the problem by establishing information centers and clinics for the guidance of alcoholics. Few of these agencies have been able, however, to formulate and set into operation a program of intensive treatment. This lack of adequate facilities for the care and rehabilitation of alcoholics has been due largely to public indifference, based on the erroneous belief that alcoholics are constitutionally inadequate individuals, demoralized beyond repair.

There is a growing awareness, however, even among the laity, that among chronic alcoholics, one may not infrequently find individuals of great ability—men who have turned to alcohol in order to achieve relief from their psychic burdens and pains.

Students of the problem long ago realized that alcoholism implies a mind in turmoil, torn with fears and frustrations. They recognized that the alcoholic seeks in drink relief from intense emotional distress. But what are the factors that underlie the alcoholic's desperate search for oblivion? Dr. Karpman's detailed study, *The Alcoholic Woman,* is an attempt to answer this question.

In this book Dr. Karpman traces the lives of three women who are alcoholics. In an attempt to uncover the various factors that

motivated the behavior of these women, he analyzes their conscious memories and explores the deep recesses of their unconscious minds. He shows how the roots of the attitudes, aspirations, and emotional make-up of the alcoholic extend far back into the formative period of growth, especially the early parent-child relationship. He follows the development of the character deviation of the alcoholic woman to the point where it begins to interfere with her adjustment to the group in which she lives. Her realization that she is different, her intense feeling of inferiority, her sense of loneliness constitute a fertile field for the development of chronic alcoholism.

In common with the alcoholic man, the alcoholic woman soon discovers that alcohol loosens her inhibitions, allays her anxieties, eliminates care, and induces pleasurable feelings. From then on she becomes a slave to drink. Sobering up merely means a return to drab reality and a realization of her hopeless state. The way out is a desperate attempt to recapture the moments of bliss through further drinking.

Three lives doomed to self-destruction as a result of unpreparedness to face life are portrayed by Dr. Karpman. In common with other students of the problem, he traces the cause of drinking to the neglect, undue severity, and stupidity of parents. His outlook concerning the promise of treatment is pessimistic. His study points out that the ultimate solution lies in the field of mental hygiene.

The book is an invaluable addition to the scanty literature on chronic alcoholism.

SAMUEL PASTER.

Memphis, Tennessee.

SIGMUND FREUD: AN INTRODUCTION. By Walter Hollitscher. New York: Oxford University Press, 1947. 119 p.

The laudable intent of the author of this book is to orient the reader in Freud's psychology of the individual so basically and clearly that its application to group dynamics is made logical. This he wishes to accomplish through his own self-effacement, which obviously is impossible. In mass action certain dynamic activities and end results are precipitated that are interrelated with individual dynamics and yet are different. The author is aware of this, and when he sticks to the straight line of Freud's basic concepts, he performs his intent well. Understandably, however, he imparts his own reactions to Freud's individual psychology, and these reactions are put in print in the chapter *"Civilized" Sexual Morality and Modern Nervousness.* Therein he has moved away from his basic resolution to make himself as little seen and heard as possible. One does not differ from the author in his philosophy, but he has moved over definitely to the area

of applied science, this in spite of his intent to be a mouthpiece only. This chapter is Hollitscher, by way of Freud.

The perplexity that haunts any effort to apply Freud's investigation of the individual and his findings to group psychology is conditioned by two factors: (1) the investigator's own resistances or receptivity to that knowledge, and (2) the, as yet, only vaguely appreciated transmutation of dynamic phenomena when the individual becomes a unit in a mass. Hollitscher sees some of these difficulties, and although as an end result there may be what he refers to as a pseudo-social psychology, nevertheless the psychoanalytic literature (as he himself knows) offers considerable enlightenment; and this reviewer would emphasize, for the reader's knowledge, that Freud's meta-psychological works, although often alluded to as philosophical, have much to offer. Other psychoanalytic investigators have added enough to serve as a base for further research on group phenomena. The current interest in group therapy should offer additional data, incipient and exploratory as these activities now are.

The consummation of any system of *mores* is the precipitant of group dynamics. The gestation and birth of any political or economic or social trend carries with it much of initial resistance, ofttimes threatening the very survival of the innovator. Is it possible that, as we become more familiar with the physio-psychology of anxiety as it works in group as well as in individual egos, we shall attain more insight into the phenomenon of progress? While the author indicated that he did not wish to show how, in his opinion, psychoanalysis should *not* be applied to social psychology, yet the very purpose of any publication is essentially affirmative as well as negative.

The survival of civilization is based on our knowledge and constructive application of sociological interrelationships. The lag between diplomacy and the will of its individuals is tragic. The knowledge of the reason for this lag is urgent, if we are to survive, and every effort to construct a bridge needs and should have our unreserved encouragement. This is a timely effort.

EDWARD LISS.

New York City.

TELEPATHY AND MEDICAL PSYCHOLOGY. By Jan Ehrenwald, M.D., with a Foreword by Gardner Murphy. New York: W. W. Norton and Company, 1948. 212 p.

Faith is a poor foundation from which to start scientific investigation. Lack of faith is an equally poor reason for rejecting conscientious effort. This book must be read with those two facts in mind.

No one can fail to be intrigued by the author's presentation of what he refers to as "the scatter theory." The author seems to say that the recipient of a telepathic idea may hit the idea exactly or may make near misses which have to be interpreted according to the recipient's individual type of symbolism. This the author pictures as a scattering similar to that which might occur around a specific bull's-eye on a target.

He then goes on to talk about scatter in time and suggests near misses that might occur after the target has ceased to exist. Up to this point we are still in an area in which it is not too difficult to think without violence to our accepted beliefs.

The author then suggests that it may be possible to make near misses in time before the target has actually come into existence, before the idea that is to be transmitted by telepathy has actually taken shape in the sender's mind. The idea is intriguing and can form the basis for a great deal of philosophical discussion. Dr. Ehrenwald's presentation of it must be read to be appreciated.

The section on telepathy and paranoia will also intrigue some psychiatrists. The idea seems to be that certain paranoid individuals are more than normally sensitive to the hostile and aggressive emotions that at times occur in all of us. Instead of projecting hostility on to other individuals, it is suggested that the paranoid simply receives hostile feelings sent toward him by others. Any one who has dealt with paranoid patients will enjoy considering this idea.

Whether you believe or not, if any two of you will read this book, you can use it as a basis for prolonged and intriguing discussions.

G. H. Preston.

Baltimore, Maryland.

The Practical Nurse. By Dorothy Deming. New York: The Commonwealth Fund, 1947. 370 p.

This book presents an extensive survey of the literature on practical nursing both before and since the organization of professional nursing. The number of articles and books listed at the end of each chapter indicates that Miss Deming has been painstakingly diligent in the preparation of the book. Many useful quotations and tables from these references have been included in the text.

Chapters I and II deal with the historical background of practical nursing and present a composite picture of the modern practical nurse—her age, her education, her personal qualifications, her previous occupation, and her reasons for choosing this profession.

Miss Deming presents five essential steps for improving the nursing care of sick patients by the practical nurse. These are (1) selection

and training of candidates, (2) licensure, (3) placement, (4) supervision, and (5) public education.

1. While an eighth-grade level of education is considered the minimum, two years of high school is regarded as desirable. "Ability to handle the scholastic program is the real test." It is suggested that the selection and control of practical nurses be in the hands of the directors of the schools for practical nursing, and that the directors be "ruthless in weeding out candidates unfitted to nurse or carry the responsibility of a home where there is illness." The control of numbers to prevent overproduction is also emphasized. The curriculum for practical nurses is compared with the training of professional nurses, but without evaluation.

2. Legislation requiring licensure is offered as a means of protecting the public, presumably from the substitution of a practical for a professionally trained nurse. Official registers, which would to some extent offer sponsorship to those registered, are suggested as a means of control and placement.

3. While home nursing probably offers the widest and perhaps most rewarding opportunities for a practical nurse, opportunities in general, mental, and tuberculosis hospitals are also considered. Care of the chronically ill, of the aged, and of convalescents, in industry, in public-health and government institutions, and nursing in offices, in school and college infirmaries, in homes for the handicapped, in children's institutions, and in summer camps are added suggestions. For those whose basic education, personal abilities, and interest qualify them, there are the possibilities of working as physical therapists, occupational therapists, technicians, medical artists, medical record librarians, or medical secretaries. Activities that take the practical nurses away from the immediate care of the sick and ill, such as specialized invalid cookery and serving as matron in industrial and other schools that care for the foster child, are also mentioned as employment possibilities.

4. Supervision, Miss Deming believes, can best be done by professional nurses, although just how this is to be accomplished is not clear.

5. Educating the public in the use of practical nurses seems a little like "carrying coals to Newcastle." The public has been employing practical nurses, either at the suggestion of a physician or because of preference, and will probably continue to do so.

The fundamental reason for the current interest in practical nurses, it is pointed out, is that she is the only person available to eke out the insufficient supply of professional nurses needed. In times of great need, as during the recent war, those who offer the best conditions of work and the most money will probably be best supplied

with the nursing service that they require. Unfortunately, the organization and control of the education of the practical nurse, and the licensing and regulating of her practice, will not provide families in remote rural areas with the competent housekeeping nurses who are so often needed. The practical nurse is not a panacea for social, economic, and other needs.

Miss Deming is to be commended for the extensive research indicated in the preparation of this book. Although the specific information that would be of most use for guidance in selecting practical nursing as a vocation may not always be present, this book should prove most useful to hospitals and agencies that are considering the establishment of courses for practical nurses.

MARY E. CORCORAN.

U. S. Public Health Service,
Bethesda, Maryland.

PRACTICAL PSYCHIATRY AND MENTAL HYGIENE. By Samuel W. Hartwell, M.D. New York: McGraw-Hill Book Company, 1947. 439 p.

This book has as its stated objectives: to help the student (nurse) develop an interest in psychiatry; to make psychiatry more easily understood; to make the teaching of psychiatry more practical; and to permit the flexible use of this particular text. This last objective is made possible by dividing the book into four parts so that, the brevity of the student's psychiatric affiliation not permitting study of the whole book, some of the parts may be omitted.

The first part, a brief overview of the total problem, gives space to the topic, "Is Psychiatry a Useful Part of a Nurse's Education?" This tenet has so long been accepted even by the most conservative nurse educators that it seems unnecessary to labor the point.

The second part, *Medical Psychology,* gives in general terms sound, understandable concepts of such matters as psychobiology, structure of the mind, and clinical evidence in support of theories of psychoanalysis. These topics in the space allotted are of necessity handled briefly, but adequately, and without controversial facets.

Part 3 is divided into three sections: *Etiology, Symptomatology, and Classification of Mental Disorders; Organic Psychoses;* and *Psychogenic Psychoses.* This is the meat of the book and it occupies more than one-half of the text. The classic etiology, which includes such items as marital status, race, and the still accepted physiological factors, is discussed clearly and succinctly. Symptomatology also follows the accepted pattern, such as disorders of apperception, memory, and so on.

A serious lack, however, in this area is discussion of the mental mechanisms, normal and pathological. These, with long and continued use, lead into much of the symptomatology. Also, in teaching students, the greater number of whom have had psychology of the normal individual or educational psychology, a definite link can be made between early and later learnings. These mechanisms are defined in the glossary and a few, by name only, are given in the text. The student is then referred to further discussion of mechanisms in *The Human Mind* by Menninger.

Part 4 contains a lucid, welcome, and definitive discussion of mental hygiene, divided into five chapters on the most important period, childhood, and one on adult life. The subject of each chapter is put in the form of a practical question with as concrete and specific answers as can be managed on this somewhat abstruse subject. Case material drives home the points made. Also, though not so labeled, preventive aspects are well-covered by inference and deduction. For the student, a restatement of actual principles and methods of prevention would have been helpful.

A topic in this part which appears all too infrequently in texts for nursing students is that of the psychiatric case history. The practical point made in the author's discussion, Chapter 13, is the unquestioned value of a good history in the care and treatment of the patient. There is brief mention of two values of such a history for the student historian. Important values not mentioned are the therapeutic reassurance and assistance to the informants if a nurse takes the history, and the social aspects of future plans for placement when the patient improves or recovers. This latter point is of great importance to the student in her comprehension of such topics in etiology as "stress of environment." The student learns rapidly as the facts and attitudes are revealed to her through actual use of the outline for an anamnesis, which is included in Chapter 13.

In conclusion, this book is referred to specifically as a text for students who will not have clinical experience with psychiatric patients and for those who will not wish to continue in psychiatric nursing as graduate nurses. Therefore—and perhaps for reasons not clearly obvious—there is no attempt to discuss the principles of psychiatric-nursing practice. This would seem, therefore, to put the book automatically into the reference group, one of many to be used as teaching aids.

There may be some question, with these two specific groups of students, whether it might not have been more helpful to them to put the emphasis on what to do rather than on the why of the patient's thinking, feeling, and acting. Both areas are equally important. The book should be of definite use in the area of helping

students to a better understanding of the dynamics and prevention of mental disorders.

ELOISE A. SHIELDS.

Norwich State Hospital,
Norwich, Connecticut.

SUCCESSFUL MARRIAGE. (AN AUTHORITATIVE GUIDE TO PROBLEMS RELATED TO MARRIAGE FROM THE BEGINNING OF SEXUAL ATTRACTION TO MATRIMONY AND THE SUCCESSFUL REARING OF A FAMILY.) Edited by Morris Fishbein, M.D. and Ernest W. Burgess. Garden City, New York: Doubleday and Company, 1947. 547 p.

No small part of the significance of this handbook of instruction for the general reader lies in the fact that one of its editors is editor also of the *Journal of the American Medical Association.* Because of this, and because fifteen of the thirty-eight collaborators are physicians, the book will appeal to doctors, who will feel that they can recommend it to patients who come for premarital examination and conference. This book is, therefore, important as an evidence of growing interest on the part of the medical profession in marriage counseling. It should also prove a strong stimulus to further popular interest along this line.

Beginning with a statement on the profession of marriage counseling, the book considers next the problems related to falling in love, choosing a mate, courtship, and the premarital examination. This is followed by a section on marriage itself, treating mainly the sexual aspect, both in its physiological and in its psychological aspects, but dealing briefly also with the problem of money. Part III discusses conception, pregnancy, and childbirth. Part IV considers the child in the family, and Part V various social problems of the family, like prostitution, venereal disease, and divorce.

It would be difficult to assemble thirty-eight specialists who are more distinguished than the panel of writers who have produced this book. Since fifteen are physicians, it is not surprising that the physical aspects of sex should receive considerable attention. Physicians, to be sure, can write with authority and with entire appropriateness on the subject of sex, but this does not justify a distribution of emphasis that makes so much of sex and so little of the total emotional life or the total personality, of which sex is only a function, although a highly important one. It is to be regretted that this book, excellent as it is, does not offer a better balanced treatment of the factors in successful marriage.

M. F. NIMKOFF.

Bucknell University, Lewisburg, Pennsylvania.

MEN AT WORK: THE SUPERVISOR AND HIS PEOPLE. By Keeve Brodman, M.D. Chicago: Cloud, 1947. 191 p.

The author draws upon his experience with the Cornell-Caterpillar Program (a project for the improvement of human relations) for the conversations with the foreman, Joe, related in this book. Joe is "a composite" of kindly, efficient persons in supervisory positions who have found ways of dealing successfully with the men they supervise. The supervisory problems presented in the form of personal stories or reports of conversations are familiar to any member of management sensitive to human relations. The interpretations of the behavior described are sound and practical.

While Joe at times helps to explain the employee's difficulties to him, he usually functions as a good listener and a kindly guide. His sense of his own personal responsibility for the welfare of the employee keeps him alert and ready to refer his men to the appropriate sources of special help within the plant. The accounts set forth the simple steps that may be taken by the supervisor in directing the individual employee and his associates so as to improve his production rate and his relationship to others on the job.

The author makes it clear that individual workers are subject to uncertainty, insecurity, worry, and specific fears. These attitudes may develop beyond what is for the particular individual a critical point. His production is affected. He gets into difficulty with his fellow employees. Joe, the foreman, notes that a problem exists. He withstands the temptation to respond to surface symptoms as if they constituted *the* problem and looks for underlying causes.

The untrained, the slow-learner, the over-conscientious, the uncooperative, the complainer, and the man who is hard-done-by appear with other familiars in the pages of *Men at Work*. The situations they create are met. Some of the "causes" can be summed up as the result of temporary conditions within or without the plant. Others are based on the well-developed anxieties that are commonly recognized as "nervousness" or minor mental disorders. The significant fact throughout is the ability of a willing, understanding person to do something about the underlying problems rather than to discharge responsibilities by the use of disciplinary measures.

One rather serious limitation to the effectiveness of this book with those for whom it was obviously written is that the composite supervisor, "Joe," is too perfect. He embodies almost too much wisdom, patience, tact, and competency to be human. The supervisor who needs the help Joe's example can bring, but who is exasperated by a particular person or situation, may feel offended by the contrast with his own personal limitations.

ESTHER H. DE WEERDT.
Wisconsin Society for Mental Health,
Beloit, Wisconsin.

WAR, POLITICS, AND INSANITY. By C. S. Bluemel. Denver: The World Press, 1948. 121 p.

This book seeks to identify "the psychological traits which bring a man to rank and power in public life and to suggest a formula which might protect society against leaders of the abnormal type" (p. 54). "It would be interesting to read a volume of history which dealt not so much with the masters of men and their feats of conquest as with the personality disorders which impelled them to their particular course of action. Such a history would deal with hypomania, schizophrenia, and similar topics; and it would mention wars and conquests only in connection with the psychoses which engendered them. In the appraisal of history, hypomania is as important as gunpowder; and schizophrenia may be as significant as the atomic bomb" (p. 65).

Every contribution toward understanding the causes of war is to be welcomed, and much can be said for the thesis that violent behaviors can be traced back to the social organization which has failed to afford better outlets for human urgings. Another cardinal cause of war may be the one that impresses the writer of this book—namely, that national leadership so often falls to men of abnormal mental make-up. He says, for example, that in Hitler, Mussolini, Stalin, can be seen a pattern of resentment going back to childhood revolt against a tyrannical parent. Russia's abnormal use of the veto may thus be expressing Stalin's negativism.

Yet obsessions, Bluemel grants, may be socially helpful rather than destructive, as in the life of Gandhi and Clifford Beers, who founded The National Committee for Mental Hygiene.

The book is useful within its limits. The author selects as politicians those who illustrate the theory of obsession. He gives only passing mention to Washington, Madison, Jefferson, and says nothing about Franklin or Lincoln. In labor politics, he deals with John L. Lewis, but not with Sidney Hillman, who was also a successful leader. He is all for democracy and wants it to be more selective. It is, therefore, to be hoped that he will give us a study of the reasons why, in a democracy, the Hitlers and the Stalins cannot go very far. Here he has limited himself to the useful inquiry already mentioned.

HENRY NEUMANN.

Brooklyn Society for Ethical Culture.

MY DEAR EGO; A LOOK IN THE MIRROR. By Fritz Kunkel. Boston: The Pilgrim's Press, 1947. 147 p.

This book is written for young people and it puts its message into a gay, whimsical, humorous form that arrests and holds the attention at once.

In Part One, *I and We,* the ego is defined as the ideas, hopes, desires, and fears that each individual has about himself. Out of these elements he forms a double-faced image—on the positive side what he would like to be, and on the negative side what he fears he is not or cannot be. The root of failure to attain a longed-for goal lies in the individual's wish for his own happiness regardless of the welfare of others. This selfishness or egocentricity is common to all of us. Differences are only in degree.

This point is illustrated by a diagram of the thermometer of egocentricity. At the top are our wishes, at the bottom are our fears and dreads. Exactly halfway between, at zero, is the we-experience. This diagram is to be used as a study chart, and a list of carefully phrased and suggestive questions follows to aid in the student's analysis of his own personality. Egocentricity leads us into the doghouse of defeat and discouragement which is another natural and necessary human experience that must be worked through and understood in order that maturity may be achieved. The we-experience must replace the egocentricity that led us into the doghouse.

Part Two, *Boy and Girl,* should be exceptionally helpful to present-day young people. Its chapter headings and captions will give an idea of its theme and of the fast-moving style of presentation: *Danger! High Voltage!; Crazy Equations; Short Circuits; How to Prevent Short Circuits; The Great Oath; Search for New Obstacles; How to Control Our Speed; Not Too Fast—Not Too Slow; The Ten Years' Course; The First Five Years; How to Readjust Our Schedule.* As in Part One, diagrams and questions are freely used to help the student in his thinking.

Part Three is entitled *Individual Group and God.* The first three chapters discuss the war of independence, with its growing pains and its black and white giants, and suggest how to make peace with former giants. The second chapter, *Two Worlds,* presents three case histories illustrative of the problems involved in making our world one world. The final chapter of the book, *The Great Magnet,* discusses the meaning of life and how to become part of the Infinite Magnet.

The line drawings by Janet Smiley throughout the book are charming and add the spice of whimsical humor to the text.

JULIA MATHEWS.

Child Guidance Clinic of Los Angeles.

OVERCOME STAMMERING. By Charles Pellman. New York: The Beechurst Press, 1947. 160 p.

This book was written to describe a method used successfully by the author in the treatment of speech disorders.

The major portion of the text is devoted to a review of the main training methods employed in the handling of stutterers. Although the author decries the pedagogic approach, he does nothing more than offer a pedagogic approach of his own. His contribution (for which he claims no originality) is the advocacy of the training of stutterers to speak correctly by emphasizing the vocalization of vowel sounds rather than consonants. He claims that when training efforts are directed to the consonants, there is marked self-consciousness and artificiality of speech. He bases his method on the statement that children learn to speak through the imitation of vowel tones before they can articulate the consonants. In other respects the method does not differ from the speech drills used by other pedagogic approaches. This statement by the author is illustrative: "Control passes from the direct control previously practiced to a marginal conscious control."

The author presents some of the well-known superficial mental-hygiene concepts of the causes of stuttering. Most of this material consists of quotations from other authors. He gives great emphasis to one writer who describes "well-adjusted stutterers," to discredit the emotional factors. Apparently the author and the man he quotes are not acquainted with the psychological phenomenon of isolation. The author dismisses the etiology of the disorder with statements such as: "The speech faculty suffers from an eccentric and wayward development because of neuro-muscular unbalance." This neuro-muscular unbalance he concedes may be due to "odd nervous reactions that crop up in the normal pace of speech development." He does not, of course, attempt to define these "odd nervous reactions." This would be thoroughly excusable if he did not display his own lack of erudition by deprecating psychoanalysis as a "complete failure," and state that "one must take cognizance of the everyday problems of the stammerer, rather than deal solely with the love instinct." It is a bit presumptuous of the author to say that psychoanalysis deals *only* with the love instinct and ignores everyday problems.

There is no doubt in the mind of the reviewer that the author has attained eminent success with the methods he describes. Otherwise there would be no excuse for the book. He has, however, failed to document his contribution with a single successful case history that involved the use of the vowel-emphasis technique. Assuming that the author has attained some successes, this reviewer would explain these along the same psychoanalytic lines that the author deprecates.

No mention is made in the book of the importance of the interpersonal relationship between the therapist and the stutterer. There

is no doubt in the mind of the reviewer that any method employed will be successful if there is a meaningful and fruitful relationship between pupil and teacher. If the teacher is kindly, patient, and interested, many stutterers, especially children, will relax their tension. Class discussions leading to group interaction will give some pupils emotional release. This may happen in spite of the efforts of the author, who advocates *telling* the pupils that they should not worry and that they *should* clear up their problems.

Although the author constantly stresses the concept that the stutterer suffers from fear, apparently he loses sight completely of the more basic element exhibited by stutterers—repressed hostility. The autobiographical sketch of the author's brother, which constitutes the last chapter of the book, is illustrative of the terrific resentment often found in this type of patient.

The reviewer offers a possible explanation of the alleged superiority of the vowel emphasis over the consonant. As the hostility of the stutterer is of an oral-sadistic type, all oral expression of a hostile nature would normally be a region of conflict. Consonants are of such a nature. Any one mouthing consonants can readily reproduce the aggressive quality of the sounds. Vowels, on the other hand, have an affectionate, loving quality. This, too, can be subjectively evaluated. By emphasizing the vowel sounds and by-passing the consonants, the tendency to deëmphasize the aggressive, hostile aspects of speech can be developed. In the reviewer's opinion, if there is any value or superiority of vowel emphasis over that of consonants, this is the reason for it.

JOSEPH C. SOLOMON.

Mount Zion Hospital,
San Francisco.

REDIRECTING THE DELINQUENT. Edited by Marjorie Bell. New York: National Probation and Parole Association, 1948. 315 p.

This book, the 1947 Yearbook of the National Probation and Parole Association, includes twenty papers given at the Fortieth Annual Conference of the Association in San Francisco, April, 1947, and at other conferences.

The contents cover a wide range of topics which are most timely in view of the growing concern about delinquency and crime. The twenty papers are treated under nine headings: *State Administration, The Adult Offender, The Radio and the Movies, Police Checks on Delinquency, Understanding the Delinquent, The Juvenile Court, Staff Training, The Courts and the Public,* and *Legal Digest.*

The importance of basing programs on a careful continuing study of conditions; the establishment of a state commission on crime and

delinquency; an indeterminate-sentence law; diagnostic units; diversified institutions based on age, sex, criminal experience, degree of custody, and mental condition; and a continuing program of study and research are stressed in "planning a state correctional system" and in other papers. The relationship between delinquency and crime and psychoneuroses, broken homes, rejection in early childhood, frustration and failure, and alcoholism as found in the adult offender is also emphasized.

The use of case-work techniques is stressed in the papers on probation, as is the need for professionally trained workers.

The picture, as given in the yearbook, in regard to the relationship between movies and the radio and juvenile delinquency is not clear or complete. One study reported on indicates that movies influenced one delinquent boy in ten in becoming delinquent; another, that the proportion was about one delinquent boy in six, and one delinquent girl in four. Other studies indicate little influence toward immediate disturbing reactions, but more influence on children's long-time attitudes, and point out that this influence is largely in terms of the social climate in which they have been reared and their state of preparedness.

More general agreement appears on the power of motion pictures and the radio in influencing attitudes and formulating ideas and opinions. A constructive program of action for the better use of these media includes helping the child to develop a critical appreciation of motion pictures and of radio programs through definite courses in school, through use of the Motion Picture Association's children's film library, and through liaison committees of the Parent-Teacher Association and other groups.

According to the yearbook, the place that the police occupy in prevention and treatment is increasing in importance. Modern police departments are considered to have four functions in this field: "first, the discovery of delinquents and of conditions tending to create delinquency; second, investigation; third, the referral of the child or the treatment of the child and his problem; and fourth, protection." In the opinion of one of the contributors to the yearbook, these functions should be performed in connection with a crime-prevention division in cities of over 100,000 population. The same author also stresses the importance of written agreements between the police department and other agencies. Other writers suggest that the police serve on boards of agencies and participate more closely in welfare activities.

The place of the mental-hygiene team in understanding and treating the delinquent and the way in which this team operates are discussed in two papers. The use of personality tests is well described by a psychologist.

An excellent description, by Lillian L. Johnson, of group study and the treatment of children adds to the value of the book.

One of the most constructive and valuable parts of the book is found in the two papers that describe the differentiation in function and responsibility of the juvenile court and welfare agencies. All too often, confusion and conflict have characterized the relationships between these two types of agency. In the two papers, one by Alice Scott Nutt and the other by Laura L. Mead, careful analyses are made of the rôle of each type of agency in a well-organized community.

Staff training in a probation department is described as necessary and the principles of such training are emphasized. The legal digest gives a short summary of the laws and decisions that affected juvenile courts, probation, and parole in 1947.

The volume ends with a discussion of the activities of the National Probation and Parole Association during the year.

The book appealed to the reviewer as one of the best in the association's history. It is well worth consideration for staff training courses and as required reading by probation and parole staffs. It can also be read with profit by interested laymen in this field.

HERBERT D. WILLIAMS.

Juvenile Welfare Board of Pinellas County,
St. Petersburg, Florida.

FOUNDATIONS OF PSYCHOLOGY. Edited by Edward Garrigues Boring, Herbert Sidney Langfeld, and Harry Porter Weld. New York: John Wiley and Sons, 1948. 632 p.

In their preface, the editors of this book comment on the acquisition of much new and valuable psychological knowledge in the past several years. Along with this, a clearly distinguishable change in point of view is remarked. The combined impacts of these two facts created a need for a new textbook, the third under this combined editorship.

Historically, this series of publications—*Psychology, A Factual Textbook* (1935), *Introduction to Psychology* (1939), and *Foundations of Psychology* (1948)—reflects the progressive assembling of new data and the change in point of view in the fields of psychology.

While changes and modifications in the material presented are apparent, one is impressed with the fact that psychology has attained a degree of maturity such that these necessary changes do not cause disturbances that tend to result in a disintegration of the whole organization. Modern psychology is eclectic. No longer do schools war with one another over which system represents the true psychology.

Those of us who are responsible for instructing students in elementary psychology will find in *Foundations of Psychology* a compilation

of durable teaching material. The manner of presentation is definitely not dogmatic. The student is never given the impression that the text represents the final word, but he is given a newer view, after he has been shown where and how this newer view is to be preferred to the older. Possibilities and probabilities for future developments in the framework of psychology are presented here and there in the book.

Each of the contributors—Anne Anastasi, M. E. Bitterman, Edwin G. Boring, Hadley Cantril, Leonard Carmichael, Leo P. Crespi, Forrest L. Dimmick, Frank A. Geldard, Donald R. Griffin, Carl I. Howland, William A. Hunt, Donald W. MacKinnon, Clifford T. Morgan, Edwin B. Newman, Carl Pfaffmann, T. A. Ryan, Lawrence F. Shaffer, Carroll L. Shartle, and S. Smith Stevens—has presented material on subjects about which he is an authority. In any such compendium, the reader, according to his special interests, will think of topics that he would wish were included. If, however, he considers the general purpose of this textbook, he will realize that the selection has been a judicious one and that the organization follows consistently an explicitly stated plan.

Because of their function, textbooks must of necessity be conservative. They consolidate material behind the battle lines, so to speak. They demarcate the firmly won areas. *Foundations of Psychology*, of 1948, includes sections on mental hygiene in childhood and mental hygiene for adults within a thirty-four-page chapter on personal adjustment.

Following each of the twenty-five chapters that comprise the book, there are annotated references.

EDWARD S. KIP.

Bureau of Mental Hygiene, State Department of Health, Hartford, Connecticut

THE PSYCHOLOGY OF ABNORMAL PEOPLE. By John J. B. Morgan and George D. Lovell. New York: Longmans, Green, and Company, 1948. 673 p.

In an effort—and a successful one it is—to revise an already well-written volume, the authors have put into one book an outline of the psychology of abnormal people. Eighteen chapters, with extensive bibliographies, a glossary, and a descriptive index, offer valuable sources of data to the beginner, who will be impressed very early by the quantitative rather than the qualitative differences in human behavior, normal and abnormal. The style is fairly free of undefined technical terms; no assumption is made of the student's technical knowledge of allied fields.

The chapter, *Psychotherapy and Treatment*, though necessarily brief in its discussion of various techniques, is pleasing in its com-

pleteness and its modern approach. There is a commendable absence of over-enthusiasm concerning some of the elements in treatment now being investigated. The chapter on schizophrenia, though good from a descriptive point of view, might have been extended to include a more well-integrated dynamic approach.

The over-all impression of the book is excellent and it can be recommended for students of abnormal psychology.

LEON YOCHELSON, M.D.

Saint Elizabeths Hospital, Washington, D. C.

THERAPEUTIC AND INDUSTRIAL USES OF MUSIC: A REVIEW OF THE LITERATURE. By Doris Soibelman. New York: Columbia University Press, 1948. 274 p.

The author has rendered a great service in this complete and critical review of the literature on the therapeutic and industrial uses of music. The text will be of inestimable value to all students who wish to formulate what music can do as an important part of the program therapies in a hospital. Topics for further research will be suggested and much time and effort can be saved in not repeating work that has been done. The same applies to the use of music in industry.

In many of our mental hospitals we are over a hundred years behind the times in arranging elaborate and interesting program therapies such as occupational-therapy, physical-education, and music departments. These were a part of the vision of those who strongly advocated moral treatment of the mentally sick. It is hoped that music will be used widely in an empirical fashion, with testing and research to follow. This is certainly implied. The author stresses the value of music from the point of view of recreation, diversion, and resocialization. Any one with practical experience in this field can heartily endorse all that is said. The reviewer highly recommends the book to all students in the field, and to all who now have, or who are contemplating, the use of music in hospitals or in industry.

JAMES H. WALL.

New York Hospital—Westchester Division,
White Plains, N. Y.

NOTES AND COMMENTS

The National Committee for Mental Hygiene Establishes Three New Divisions

The National Committee for Mental Hygiene is planning to extend its work through the institution of three new divisions—a division of state and local organization, a division of education, and a division of world affairs. Miss Marian McBee, formerly Executive Secretary of the New York Committee on Mental Hygiene, of the State Charities Aid Association, is director of the division on state and local organization. She will put into effect on a national scale the program that she and her associates have been conducting in New York State. The new division of education is headed by Dr. Nina Ridenour, who, as Executive Officer of the International Committee for Mental Hygiene, was largely responsible for organizing the United States' part in the International Conference on Mental Hygiene held in London in August, 1948. The director of the division on world affairs is Mrs. Grace O'Neill, who has been acting as research consultant for the International Committee for Mental Hygiene.

Executive Board of World Health Organization Recommends $942,550 for First International Mental-Health Program in 1950

The first international program of mental health was approved March 2, 1949, by the Executive Board of the World Health Organization and will be submitted to the second World Health Assembly, meeting next June in Rome. Five other health projects were also endorsed: on environmental sanitation, on tuberculosis, on venereal diseases, on mother and child health, and on cholera.

The mental-health program approved to-day includes the collection and dissemination of information, field surveys, and team demonstrations of methods of survey, prevention, and treatment of mental disorders.

The executive board agreed that field surveys should be carried out to investigate mental-health problems in rural communities, in industrial units, and among students. It was pointed out that work in mental hygiene has so far been developed predominantly in an urban setting and that little is known of the mental-health problems of rural communities and the necessary preventive measures. Simi-

larly in urban communities, certain segments of mental-health work have had a much greater impact, for instance, on the family and the infant school than on the university and the industrial unit.

The socio-economic significance of mental ill health was mentioned in this connection. The true incidence of mental morbidity arising in industrial and in student groups is unknown. The only statistically planned investigation of the incidence of psychoneuroses in an industrial community was carried out in the United Kingdom. This investigation demonstrated that these disorders cause a loss of productive time even greater than the common cold (chief cause for absenteeism in industry). On the North American continent, it was further pointed out, surveys have shown that from 40 to 60 per cent of the patients who consult general practitioners are suffering from disorders predominantly psychological in origin.

Even less has been done in the field of student mental hygiene, the board noted. Yet the individual in the student stage of his development is in a plastic phase in which incipient mental-health problems may often be dissipated by skilled help and their incidence much reduced by preventive measures.

The board further noted that the program proposed to it had been prepared according to recommendations made by the World Federation of Mental Health, and earlier approved in principle by the World Health Organization executive board.

The executive board decided also that six traveling seminar teams would be provided to demonstrate techniques of survey, prevention, and treatment of mental ill health. Demonstrations will be made in several countries in places convenient for the assembling of members of interested professions. This educational approach would be aimed at public-health personnel, mental-health workers and related professions, and to a certain degree, at the general public.

By a vote of 11 to 2, the executive board decided to accept for this program a budget of $942,550—$217,180 from the regular budget and $725,370 from the supplemental budget.

American Psychiatric Association Urges Attention to International Psychological Tensions

A statement urging the immediate attention of national leaders of all nations to the dangerous psychological features of current international tensions, and suggesting ways to relieve them, was released recently by the American Psychiatric Association, Washington, D. C. The statement was formulated by the association's Committee on International Relationships, under the chairmanship of Dr. George

H. Stevenson, Superintendent of Ontario Hospital, London, Canada. The statement in full follows:

"The American Psychiatric Association is seriously concerned about the unfortunate psychological features which are a part of the present international tensions. It believes it has a duty to offer a statement on these matters for the attention of national leaders in all countries and for the general public, whose health and welfare are intimately related to international tensions.

"The American Psychiatric Association makes this statement because psychiatrists strive to understand the psychological causes of difficult and faulty interpersonal relationships and should be able to offer some advice on their improvement. Such knowledge and advice should be applicable whether the adjustment difficulties are between individuals or groups of individuals, even national groups of individuals.

"Basically, antagonisms are due to the activity of the self-preservative tendencies and their accompanying emotions of fear or greed. The utilization of this primitive behavior, harsh and cruel as it may have appeared to the weaker strains, has led to the evolution of Man.

"But if Man is to survive and develop to still higher levels of intellectual and social achievement, should he not now utilize friendly coöperation rather than aggressive antagonisms?

"This question is directed to all national leaders because they so largely guide the feeling, thinking, and behavior of the general public in their respective nations.

"Those who have had the opportunity of observing the general public in countries other than their own realize there are only minor differences between the citizens of various countries. The friendly kindness of the common people, their willingness to work for the common good, their love of their children and their homes, their diligence and their self-sacrifice—these virtues and values are shared by nearly all people in all civilized countries.

"But if the common man begins to fear he may lose these necessary values to the good life, either by actual or threatened aggression from without, or by unfair propaganda from within by unprincipled leaders, the masses of the people may easily be induced to take a position of antagonism. They may develop anxiety and fears and even incorrect beliefs about the common people in other countries. In the unsuccessful efforts to overcome these fears and sense of insecurity, actual warfare may result.

"We psychiatrists are medical doctors, whose main function is to heal the sick and injured and to prevent sickness and injuries. Wars, especially the world wars we have seen in this century, have caused the death of millions, have left millions more with wounds, and have resulted in physical and mental ill health to still further millions. As physicians, therefore, we must regard war as a plague, a problem which should be solved by education, by the use of our hard-won intelligence, and by directing our instinctive and emotional capacities into constructive development.

"As psychiatric public-health officers, therefore, we are compelled to point out that emotions of fear and greed, cultivated to unhealthy degrees, can lead only to delusions of persecution, to hostile aggression (defensive and offensive), and ultimately to World War III.

"We would point out that mutual confidence between leaders of the people in all countries, combined with mutual honesty, mutual forbearance, mutual support—positive healthful attitudes, conveyed from the leaders to their followers—should lead to a higher, better, and healthier civilization than any we have known in the past.

"It should be pointed out, too, that the elimination of war as a public-health menace can only be achieved by rigid self-scrutiny of national motives, by the refusal to accept or give spurious rationalization for unfriendly behavior, and by the conscious achievement of sublimation of the leaders' personal aggressive hostility, which is present to some extent in every one.

"For the development of better mental-health citizens of various countries, the United Nations has set up subsidiary agencies which should be valuable in attaining this objective. One of these is the World Health Organization, which is concerned with the best possible health of people in its physical, mental, and social aspects. Another organization is U. N. E. S. C. O., one of whose objectives is the solution of social tensions, including international tensions, by the efforts of the social scientists in all countries, pooling their knowledge, experience, and effort. The American Psychiatric Association urges national leaders and the general public to support both of these organizations in their efforts to provide better mental health between nations.

"The American Psychiatric Association offers this statement as an objective medical document, not as a political criticism of any nation. The American Psychiatric Association requests that this statement, brief as it is, be given serious consideration by national leaders and their citizens. It is offered in the interests of the health of the people in all countries."

Forty-Two Medical Schools Receive Federal Funds for Undergraduate Training in Psychiatry

Forty-two medical schools in the United States are to receive federal funds, totaling $1,498,333, for developing or expanding training in psychiatry for undergraduate medical students, according to a recent announcement of the Federal Security Agency. The first funds will be made available for the school year 1949–50, and will be paid in annual allotments over a three-year period.

Upon the recommendation of the National Advisory Mental Health Council, at a meeting in Washington on December 12 and 13, the Surgeon General of the Public Health Service, Dr. Leonard A. Scheele, approved the applications of the 42 medical schools. The schools will be formally notified in the near future.

The size of each grant was determined by pro-rating the requirements of the school against the funds appropriated for the purpose under the National Mental Health Act.

Dr. Scheele expressed the hope that all eligible schools would eventually be awarded grants for this development in undergraduate medical training. At the present time, the money is not available.

The program making psychiatric training available to undergraduate medical students was developed as a result of representations by health authorities that all physicians should be familiar with the effect of the emotions on the general health of the individual. In addition, these authorities have stated that the family doctor, the heart specialist, the pediatrician, and all doctors should be trained to recognize the signs of incipient mental disturbances. As preventive medicine, it was pointed out, the importance of treating a mental condition before it becomes a serious problem is similar to that of diagnosing and treating tuberculosis or cancer in the early stages.

Responsibility for This Involves All Citizens

(From *The San Francisco News*,
February 16, 1949)

Every citizen of the state of California would be subject to imprisonment if a revision of the penal code recommended by Governor Earl Warren's Commission on Criminal Law and Procedure is adopted by the legislature.

The revision reads: "It shall be unlawful to use any cruel, corporal or unusual punishment or to inflict any treatment or wilfully permit any lack of care . . . which would injure or impair the health of any . . . person confined in any reformatory, institution, jail, state hospital or . . . county, city and county, or city institution. Any person who violates . . . this section shall be punished by imprisonment in the county jail not to exceed one year or in the state prison not to exceed five years."

Rigid interpretation of such a law could conceivably result in prosecution of every state official—and most of the public—for the long-standing, inexcusable neglect of state-hospital patients.

"Lack of care" which would "injure or impair the health" of patients is an old story in these institutions. State officials, members of the legislature, and a goodly percentage of the citizens are aware of this situation.

Listen to the words of Governor Luther Youngdahl, of Minnesota, who is crusading to correct similarly atrocious mental-hospital conditions in his state:

"Human misery knows no geographical borders. We cannot hide behind the fact that conditions in other states are comparable to ours. We cannot hide behind the fact that no one individual is solely responsible for our snake pits and bedlams. *Particeps criminis.* We have all participated in a social crime."

Governor Youngdahl quoted a Grand Jury report:

"The Grand Jury condemns the whole system that to-day allows this unholy thing to exist in our state. The responsibility is widespread and it must be met. All must share in the guilt for this social crime."

At long last, there is a possibility of taking bold, progressive action to give California a decent mental-hospital system, and a courageous program for prevention of mental disease.

The mental-health conference called by Governor Earl Warren to meet in Sacramento March 3 and 4 presents a golden opportunity to get the ball rolling.

This conference should come up with a definite short-range and long-range program for mental-hospital reform. Governor Warren and the legislature should get behind such a program without delay. An aroused public should press for early action to blast any road blocks out of the program's path.

Federal Security Agency Releases Data on Capacity, Staff, and Expenditure for Maintenance of State Mental Hospitals

The data below were recently released by the Mental Hygiene Division of the Public Health Service, Federal Security Agency:

"By the end of 1946, the war-born problem of personnel shortages in state hospitals for mental disease had eased slightly, but allied problems of overcrowding and increasing maintenance costs had been intensified. There were 70,962 full-time employees on the rolls of state hospitals at the end of 1946, making a ratio of 6.2 patients per employee. This ratio indicates a continuation of the decrease in the number of patients per employee which began in 1945 and represents a reversal of the upward trend which occurred during the war years. The percentage by which the average daily resident-patient population exceeded normal capacity increased from 12.5 in 1945 to 16.3 in 1946, and the per-capita expenditure for maintenance rose from about $387 to $437 in the same period.

"Expenditures for maintenance by state hospitals totaled $189,001,358 during 1946. Between 1937 and 1946, the per-capita expenditure increased from about $285 to about $437, or about 53.3 per cent. In the years prior to 1940, this increase indicates in some measure an increase in the adequacy of the care provided patients in these hospitals, but in the latter part of the decade it reflects the general increase in the cost of living.

"The percentage by which the average daily resident-patient population of state hospitals exceeded their normal capacity increased from 12.5 to 16.3 between 1945 and 1946. This increase reflects not only an increase in the average daily population, but also a downward revision of official figures on normal capacity in a number of states. In general, figures on normal capacity indicate, not the maximum number of beds which can be contained in a hospital, but rather the maximum number

NORMAL CAPACITY, ADMINISTRATIVE STAFF, AND EXPENDITURE FOR MAINTENANCE OF STATE HOSPITALS FOR MENTAL DISEASE: 1937 TO 1946

Year	*Normal capacity*				*Administrative staff*			*Expenditure for maintenance*		
	Average daily resident-patient population *	Normal capacity	Excess of population over capacity (overcrowding)		Average daily resident-patient population *	Full-time employees	Patients per employee †	Total expenditure	Average daily resident-patient population *	Per-capita expenditure †
			Number	Per cent of capacity						
1946	444,785	382,426	62,359	16.3	438,218	70,962	6.2	$189,001,358	432,779	$436.72
1945	435,544	387,119	48,425	12.5	429,760	63,303	6.8	165,743,122	428,498	386.80
1944	433,066	392,901	40,165	10.2	418,287	59,515	7.0	156,038,423	425,928	366.35
1943	430,186	391,206	38,980	10.0	414,376	61,083	6.8	138,491,553	412,379	335.84
1942	426,335	389,445	36,890	9.5	423,387	66,416	6.4	136,762,165	422,512	323.69
1941	414,819	380,414	34,405	9.0	406,819	70,732	5.8	125,366,478	408,871	306.62
1940	401,079	365,192	35,887	9.8	399,554	70,195	5.7	119,778,170	398,419	300.63
1939	397,150	369,172	27,978	7.6	394,114	68,742	5.7	118,388,218	395,683	299.20
1938	381,708	348,809	32,899	9.4	380,595	66,619	5.7	112,812,589	379,678	297.13
1937	369,489	333,237	36,252	10.9	368,345	63,188	5.8	104,472,946	366,903	284.74

* Includes only population of hospitals reporting specified item.
† Based on average daily resident-patient population.

of beds consistent with adequate care. It is evident, then, that during 1946 figures on normal capacity for a good many hospitals were reëvaluated in terms of higher standards of care.

"The statistics in this release cover the fiscal year ending in the calendar year. In every year in the period between 1937 and 1946, there were a few hospitals from which information on administrative staff and expenditure was not received. Likewise, there were a few years for which the statistics on normal capacity did not cover all hospitals. In view of this variation in the completeness of coverage, year-to-year comparisons of total figures should be made with caution. The coverage is sufficiently complete, however, to permit comparisons among the percentages by which average daily population exceeds normal capacity, the ratios of patients to employees, and the per-capita figures on expenditure. . . . These indexes are, in each instance, based on the aggregate average daily resident-patient population of the hospitals which reported the data in question.

"[The table on page 327] presents statistics on the normal capacity, administrative staff, and expenditure of state hospitals for the years 1937 to 1946."

Dr. Chambers to Head Mental-Hospital Inspection and Rating System

The American Psychiatric Association has announced the appointment of Dr. Ralph M. Chambers, until recently Superintendent of Taunton State Hospital, Taunton, Massachusetts, as director of the association's newly established inspection and rating system for mental hospitals in the United States and Canada. A central inspection board of 10 psychiatrists, under the chairmanship of Dr. M. A. Tarumianz, Superintendent of Delaware State Hospital, Farnhurst, Delaware, will serve as the governing body of the new system.

Made possible by grants from the Psychiatric Foundation, the inspection and rating system is designed to stimulate the same kind of voluntary improvement in public and private mental hospitals that a similar procedure developed in 1918 by the American College of Surgeons achieved in general hospitals.

As applied to mental institutions, the system, worked out after years of study, is ready to operate as follows:

Mental hospitals, public and private, will request inspection. Many already have. Qualified inspectors under Dr. Chambers' direction will then appraise every phase of the institution and its work against a set of minimum standards, covering plant, facilities, personnel, and methods of operation and administration. After inspection, recommendations will be made and a reasonable time allowed for carrying them out. If improvements are not made within the allowed period, the institution will be rated as sub-standard. Thus adminis-

trators, boards and committees, and sympathetic legislative and community leaders will be provided with a rallying point around which the community can be aroused to demand appropriations or whatever other measures may be needed.

It is pointed out that in 1918, when the American College of Surgeons instituted this procedure among general hospitals, 692 of these institutions were surveyed and only 89 were approved. In 1947, 3,900 were surveyed and 3,143 were approved.

Prior to his appointment as director of the inspection and rating service, Dr. Chambers had served since 1925 as Superintendent of the Taunton State Hospital, in Massachusetts. Before that he was Assistant to the Commissioner of the Department of Mental Diseases, in Boston, and Assistant Superintendent of the Westboro State Hospital. From 1917 to 1919, as an officer in the Reserve Medical Corps, U.S.A., he had charge of the Department of Psychiatry and Sociology in the U. S. Disciplinary Barracks at Fort Leavenworth. He is a diplomate of the American Board of Psychiatry and has taught at Tufts Medical School and the Boston University School of Medicine. He is a member of the American Medical Association, the American Psychiatric Association, The Council of The National Committee for Mental Hygiene, and the New England Society for Psychiatry.

Communications concerning the inspection and rating system should be directed to Dr. Ralph M. Chambers, c/o American Psychiatric Association, 1270 Avenue of the Americas, New York 20, N. Y.

The Hand of Fellowship

The letter below came in recently to the office of The National Committee for Mental Hygiene. We are presenting it here because we believe that others will be as touched and pleased by it as we were, and as heartened by the attitude toward the mentally ill that it reveals. The signers of this letter hold out the hand of fellowship to the mentally ill as one group of sick people to another. They have accepted unquestioningly one of the most important truths that The National Committee for Mental Hygiene has been teaching—that mental patients are not set apart from the rest of us in some strange and terrible way, but are just sick people, as much entitled to adequate care and treatment as any other sick people and as capable of recovering and taking up their normal lives again.

Some forty years ago Clifford Beers headed the prospectus of the first society for mental hygiene with the words: "After all, what the insane most need is a friend." We feel that he would

be deeply gratified by this expression of friendship and fellowship from the Triboro Hospital:

"Triboro Hospital
"Jamaica, New York
"Feb. 3, 1949

"Dear Sir,

"Listening to the program last night, *Mind in the Shadow*,[1] over WCBS opened our eyes to the 'mental health' situation.

"We are hospitalized with tuberculosis, so realize the importance of proper care and treatment. We are thankful to say that our welfare is being well taken care of. We know that campaigning for donations to fight tuberculosis has helped to make this possible.

"We feel that if the public could become more conscious of the inadequate means there are for the care of the mentally ill, steps would be taken towards changing this situation.

"I'm sure if our families or ourselves were asked to contribute towards this cause we would all do our part. We know how much it means to get well and to get well under proper conditions.

"Very truly yours,
"The Patients of Ward 7B, Triboro Hospital"

National Mental Health Week to Be Observed in April

National Mental Health Week, initiated by the Junior Chamber of Commerce, will be observed from April 24 to 30. The President of the United States and many governors are expected to issue proclamations concerning it. The National Committee for Mental Hygiene is offering suggestions to state and local mental-hygiene societies and other interested groups and agencies about planning events for the occasion. This is an unusual opportunity to direct public attention to community mental-health resources—the many agencies whose work contribute to building wholesome citizens—as well as to the need for improving conditions in institutions for the care of the mentally ill.

The International Congress of Criminology

The first International Congress of Criminology since the collapse of the International Congresses of Criminal Anthropology was held in Rome in 1938. The second congress is to be held in Paris in 1950, immediately after the sessions of the International Psychiatric Congress. The date has not yet been determined, but the organizers will presumably take into consideration the fact that the International Prison Congress will meet in Amsterdam the same year and that the dates should be fixed close together. The chairman of the

[1] One of the Columbia Broadcasting Company's 1949 documentary series, presented on February 2 and again on February 20.

committee of organization is Professor H. Donnedieu de Vabres, eminent authority on international criminal law.

The provisional program of the congress aims (1) to provide an opportunity for criminologists of various countries to communicate to the congress the results of their researches and the improvements in their methods, although it will be necessary, in order to make the meetings productive, to insist that all papers be prepared with the principle of synthesis in mind; (2) to study the basic problem faced by the evolution of criminology—namely, that of a distinctive method for criminology; and (3) to consider and discuss the organization of an International Center of Criminology proposed by the International Society of Criminology to the committee of organization with a view to securing the opinion of the congress.

In order to coördinate the preparations for the congress, six scientific committees have been set up; one for anthropology, biology, and typology; one for psychology, psychiatry, and psychoanalysis; one for police sciences and legal medicine; one for sociology and moral and political sciences; one for penitentiary science; and one composed of specialists in juvenile delinquency from among the experts on the first five committees to deal specifically with the criminological problems of childhood. The program furthermore announces that the *Revue de Science criminelle et de Droit Penal Comparé* has been selected as the official organ for the preliminary work of the congress. The secretariat is located in the Institute of Criminology, 12 Place du Panthéon, Paris (5e).

Sixteenth Annual Conference of the Texas Society for Mental Hygiene

The Sixteenth Annual Conference of the Texas Society for Mental Hygiene met in Dallas on March 3 and 4, 1949.

At the general session that opened the conference, Dr. William C. Menninger, President of the American Psychiatric Association, and General Secretary of The Menninger Foundation, Topeka, Kansas, struck the keynote with his address, *Selling Mental Health as a Part of Everyday Life*. At the same session Dr. Ozro Woods, of Dallas, Texas, and Mr. J. P. Porter, of the editorial staff of *The Daily Texan*, held an interesting discussion about the survey that Mr. Porter had made on conditions in mental institutions in the state of Texas.

Under the direction and planning of Mrs. Edmund C. Kahn, general chairman, the conference was divided into "Seven Sections for Success"—on "School Age Problems," "Living with Handicaps," "Religion," "College Problems," "Care of the Mentally Ill," "Alco-

holism," and "Men at Work." Members of the conference were divided into institutes, workshops, and interest groups, spending the entire day of March 4 in the homes of various citizens of Dallas, discussing the particular problems in which they were interested.

The section on "School Age Problems" attracted many educators, social case-workers, and other professional and lay personnel interested in the school-age child. Colonel H. Edmund Bullis, Executive Director of the Delaware State Society for Mental Hygiene, in his discussion, *Mental Health Goals in Education,* emphasized the need for more attention to the emotional development of school children.

So large was this group that it was divided into seven subgroups, which considered specific problems. Dr. Frances Ilg, of the Yale University Child Development Clinic, met with the visiting-teacher and counselor group. Dr. Ilg pointed out the importance of individual differences among children in their development, and the need for a recognition of these developmental differences by teachers and other workers with children. She suggested methods by which school social workers may work with classroom teachers in recognizing individual differences and developmental problems of children and in evolving techniques that the teachers might use in effecting adjustments.

The section on "Living with Handicaps" was divided into three large groups, under the direction, respectively, of Dr. Ben L. Boynton, Regional Chief of the Physical Medicine Rehabilitation Division, Veterans Administration, Dallas, Texas; Dr. Margaret Watkins, orthopedic surgeon and Medical Director of the Dallas Cerebral Palsy Treatment Center; and Dr. Howard E. Heyer, associate professor of medicine, Southwestern Medical College.

Discussion and recommendations for action centered around the need for thorough community coöperation on problems of handling handicapped people from a mental-health angle, including recreation, schooling, care, and treatment.

Dr. Jasper Morton, of the Dallas Trinity Presbyterian Church, and Reverend Frederick Keuther, Executive, The Council for Clinical Training, of New York City, led the discussion on "Religion and Mental Hygiene."

At the section on "College Problems," Dr. Willis Tate, Dean of Students, Southern Methodist University, discussed the problems of individual students in colleges, and recommendations for more group-counseling efforts and more orientation for college freshmen were submitted for action.

The five large subgroups on the "Care of the Mentally Ill" were led by Mr. J. P. Porter, of *The Daily Texan;* Dr. Oscar E. Hubbard, Regional Chief of Neuropsychiatry, Veterans Administration, Dallas; Dr. Albert Pattillo, Superintendent of the Terrell (Texas) State

Hospital; Dr. A. T. Hanretta, Superintendent, Austin (Texas) State Hospital; Dr. John Waterman, of Indianapolis, Indiana; and Dr. G. C. Randall, of San Antonio, Texas. Recommendations on legal methods of commitment were made for the society's action. It was also recommended that criminally insane people be provided for in a wing of the Texas Prison System instead of being committed to state hospitals as at present.

Mrs. Gordon Sherwood, Executive Secretary of the Dallas Committee for Education in Alcoholism, and Dr. E. M. Jellinek, of the Laboratory of Applied Physiology, Yale University, led the section on alcoholism. Among other measures, the group recommended that more classes in human relations be incorporated in school systems and that alcoholism be one of the topics studied. It was also recommended that Texans be given scholarships to attend the Yale Institute Summer School.

A battery of leaders in their respective fields met with the section on "Men at Work": Dr. A. Q. Sartain, Chairman, Departments of Psychology and Personnel Administration, Southern Methodist University; Mrs. May T. Ball, of the International Garment Workers Union; E. C. McFadden, of the Employers Casualty Company; W. W. Finlay, of the Guiberson Corporation; Dr. Sadie Myers Shellow, of the Workers School and Institute of Management, University of Wisconsin; Dr. Arthur C. Eckerman, Director of Industrial Relations, H. P. Smith Company, Chicago; and Dr. William C. Menninger.

The psychiatrist in industry was discussed, and it was pointed out that psychiatrists can advise with management on the effectiveness of training programs.

The conference was also the occasion of the presentation of the Second Annual Hogg Foundation Award. Dr. Titus Harris, of Galveston, a member of the Hogg Foundation Award Committee, made the presentation, with the following citation:

> "The Texas Society for Mental Hygiene takes pleasure in announcing the person to be honored by the Second Annual Hogg Foundation Award of $250.00 for distinguished service in the cause of mental hygiene in the state of Texas.
>
> "The society names as its distinguished member the late Dr. A. Caswell Ellis. The award will be made in his memory to his wife, Mrs. Mary Ellis, who in her own right deserves to be recognized for her diligent work in the field of mental health and adult education in Texas.
>
> "Dr. Ellis was an outstanding pioneer in advancing our knowledge of the human mind and emotions. He organized the first courses in applied psychology and field work at the University of Texas; he served as a member of Governor Neff's committee appointed in 1911 to survey the mental-health facilities of the state; he was instrumental in securing the passage of legislation which changed the official concept of insanity and hospitals for the insane to the concept of state hospitals

and of a preventive mental-health program; he was active in many other types of reform related to this field.

"Following his fifteen years of absence from Texas, during which time he served as President of Cleveland College, Dr. Ellis returned, not to retire, but to carry on his mental-health and adult-education work with renewed vigor. He served many different communities as lecturer and consultant under the sponsorship of the extension division of the university and the Hogg Foundation. He was an active participant in all phases of the program of The Texas Society for Mental Hygiene.

"A fuller account of his achievements and an intimate portrayal of his warm personality will appear in a special issue of *Texas Trends* dedicated to the memory of Dr. Ellis."

Announcement was also made of a special Hogg Foundation award of $100.00 to Mr. J. P. Porter, one of the student writers on the staff of *The Daily Texan,* for his careful study of the needs of the state's mental hospitals, and his skillful and graphic portrayal of these needs through the public press, which has been recognized in the state and nationally as an outstanding achievement in the field of collegiate journalism.

Sixth Annual Conference of the American Group Therapy Association

The Sixth Annual Conference of the American Group Therapy Association was held in the Einhorn Auditorium of the Lenox Hill Hospital, 76th Street and Park Avenue in New York City, on January 21 and January 22.

The general conclave was preceded by a special conference on Friday, January 21, limited to personnel of state, county, and veteran hospitals and other institutions. One of the sessions was given over to an analysis of the aims and objectives of group psychotherapy in institutions and hospitals; another to a survey of methods currently employed.

The Friday evening session of the general conference dealt with "The Rôle of the Leader in Group Development and Therapy." Dr. Ronald Lippitt, of the University of Michigan, and Dr. S. H. Foulkes, of the London Psychoanalytic Institute, were the main speakers. Others who participated in this session were Professor Theodore Newcombe, of the University of Michigan, Dr. Jacob Moreno, Dr. Helen Durkin, Dr. Leo Berman, Dr. Fritz Redl, and Dr. G. S. Delatour.

The Saturday morning session was devoted to "Current Research in Group Psychotherapy," with papers by Dr. Hyman Spotnitz and Betty Gabriel on "Resistance in Interview Group Psychotherapy"; by S. R. Slavson, on "Basic Dynamics in Analytic Group

Psychotherapy"; and by Harriet Montague, who discussed "Levels of Regression in Activity Group Therapy." Dr. Ernest Kris, of the New School of Social Research, and a number of other discussants participated in this session.

The general topic of the Saturday afternoon meeting was "Clinical Applications of Group Psychotherapy." Dr. A. Z. Pfeffer, of Bellevue Hospital, New York, presented a wire recording of a group-psychotherapy session with psychoneurotic alcoholics; and Dr. Pearl Axelrod, of the University of California, spoke on "The Anxiety State of Adult Women in a College Setting."

Other participants in the program were Dr. Thomas A. C. Rennie, Dr. S. Bernard Wortis, Dr. Samuel B. Hadden, and Dr. Wilfred C. Hulse.

1,000 Jobs for Psychiatrists Going Begging

Nearly 1,000 jobs are going begging for lack of psychiatrists to fill them, according to a recent statement by Dr. William C. Menninger, President of the American Psychiatric Association. The total number of practicing psychiatrists in the United States is less than 5,000. Most urgently in need of psychiatrists are state mental hospitals and institutions, community clinics, and Veterans Administration hospitals. Salaries range from $4,000 to $15,000.

This striking evidence of the nation's shortage of psychiatrists turned up when the American Psychiatric Association compiled a "Roster of Job Vacancies" and released it to its members. The roster by no means includes all existing vacancies, Dr. Menninger said, nor does it reflect the nation's over-all need for psychiatrists, estimated at approximately 15,000 by the United States Public Health Service. It is merely a substantial sampling of *jobs that need to be filled to-day*.

The long and expensive training required is a major reason for the shortage of psychiatrists, Dr. Menninger explained. All recognized psychiatrists must be medical doctors with at least three years of college, four years of medical school, and a one- or two-year hospital interneship behind them. Then, to be certified as specialists in psychiatry by the American Board of Psychiatry and Neurology, they must have three more years of approved graduate training and two years of practical experience.

Also, psychiatry, being one of the newest medical specialties, has in general not been given the emphasis in medical schools accorded other, older specialties. Medical schools are gradually remedying this situation. The United States Public Health Service recently granted funds to 42 medical schools to expand their training programs in psychiatry.

The existence of these vacancies throughout the 48 states, Alaska, and Hawaii is sufficient testimony that thousands of children are not getting needed psychiatric care in community clinics; that alcoholics are being denied attention; that the stay of patients in mental hospitals is unduly prolonged; that the growth of mental-hygiene clinics throughout the country lags; and that the fruit of research projects which would speed the cure of the mentally ill is not being harvested.

An Inventory of Research Projects in Race Relations

The Committee on Education, Training, and Research in Race Relations, of the University of Chicago, in coöperation with the American Council on Race Relations, is conducting an inventory of research projects in race relations and minority-group problems, in order to make available information that will be of value to persons and agencies carrying on research and also to those engaged in action programs in the field. It is planned to issue quarterly bulletins describing current and recently completed research projects. Two bulletins have already been issued, dated June 30, 1948, and December 31, 1948. The inventory bulletins carry accounts of two kinds: (1) descriptions of studies reported in answer to the inventory questionnaire and (2) abstracts of studies contained in published articles, pamphlets, and books. All those who are engaged in research in racial and cultural relations are invited to write to the committee for the inventory questionnaire, on which they can report studies already completed or in progress. The address is Committee on Education, Training, and Research in Race Relations, The University of Chicago, 4901 Ellis Avenue, Chicago 15, Illinois.

A New Journal on Child Behavior

The management of the *Journal of Nervous and Mental Disease* and of the *Psychoanalytic Review* are sponsoring the publication of a new quarterly journal, to be devoted to the problems of childhood. The *Quarterly Journal of Child Behavior*, as the new publication is called, is the outcome of a letter of inquiry sent to a representative member of child psychiatrists, the majority of whom agreed that there was a need for a new journal in this field.

The journal will present papers on the neurological, psychological, and sociological disorders of children up to and including twelve years of age. It should also be of interest to pediatricians, psychiatric social workers, and others who deal in a professional capacity with children. The papers will be of a practical as well as of a theoretical nature. Reports of significant investigations and contri-

butions from the various schools of thought will be published as they become available.

The yearly subscription is $8.50 ($1.00 additional to addresses outside the continental United States) and the remittance should be made payable to the order of the *Quarterly Journal of Child Behavior.*

Fellowships Available in Child-Guidance-Clinic Psychiatry

The American Association of Psychiatric Clinics for Children offers fellowships for training in child-guidance-clinic psychiatry. These fellowships are made possible financially by the United States Public Health Service and sometimes by local funds. In addition, a few communities are offering to finance the training of psychiatrists who will engage to work for them on a contractual basis for a given period after their training. The training is for positions in community clinics in which psychiatrists, psychologists, social workers, and others collaborate in the treatment of children suffering from emotional illness.

Most of the fellowships are for two years; some for one. The stipend is in the neighborhood of $3,000 for the first year, and around $3,600 for the second. The awarding of the fellowship for the second year is always dependent upon the quality of the first year's work. Prerequisites are graduation from an approved medical school, a general interneship, and two years of approved general psychiatry (besides the personal qualifications essential for such work).

Opportunity is provided for the fellow to develop his own skills in a well-organized out-patient service with the support of a carefully planned training program and adequate supervision. The training centers are selected on the basis of standards that have been established by the American Association of Psychiatric Clinics for Children, and the fellowships are awarded by a committee of this organization.

For further information write to Dr. A. Z. Barhash, Executive Assistant, The American Association of Psychiatric Clinics for Children, 1790 Broadway (Room 916), New York 19, N. Y.

Training Program in Child Psychiatry Established at the New York University-Bellevue Medical Center

The Psychiatric Department of the New York University-Bellevue Medical Center announces the establishment of a program for training in child psychiatry. For this purpose, there have been designated two full-time residencies in child psychiatry. In July, 1949, there

will also be available several full-time fellowships. The facilities for training include work in the children's wards and the Out-patient Department of the Psychiatric Division of Bellevue Hospital, in the liaison service with the Department of Pediatrics, and in the Psychiatric Division of the University Hospital.

Army Trains Enlisted Men in Neuropsychiatric Fields

The Army Surgeon General's Office has announced courses of instruction in three branches of the neuropsychiatric field for enlisted personnel of the medical department. The courses will be held at the Medical Field Service School at Fort Sam Houston, Texas, beginning February 14, 1949.

The courses offered are neuropsychiatric-technician procedure, elementary psychiatric social work, and elementary clinical psychology. Successful graduates are assigned duties, respectively, as ward masters, or attendants in wards that have neuropsychiatric patients; non-professional assistants to psychiatric social workers; and non-professional assistants to clinical psychologists.

In order to qualify for training, an applicant must meet rigid requirements set forth by the medical department. To enter the course in neuropsychiatric-technician procedure, a man must have a high-school diploma and attain a score of 100 or better on the army general-classification test. In addition, he must be qualified as a medical or surgical technician, and must demonstrate that he is physically and mentally equipped to work with neuropsychiatric patients.

To qualify for one of the other two courses, the man must be a high-school graduate, have a score of 110 or better on the army general-classification test, demonstrate a desire to work with neuropsychiatric patients, and have an interest in the scientific, medical, technical, clerical, or computational field.

In each course, students are given intensive classroom work for four weeks. The remainder of the course (eighteen weeks for neuropsychiatric-technician procedure and twelve weeks for elementary psychiatric social work or elementary clinical psychology) is spent in on-the-job training.

The courses, besides preparing men to perform valuable and much needed work under the supervision of professional-officer personnel, are a part of the army's career programs for enlisted men.

Yale Summer School of Alcohol Studies to Hold Eastern and Western Sessions in 1949

The Summer School of Alcohol Studies, conducted annually, since 1943, by the Laboratory of Applied Physiology of Yale University,

will hold two separate, but equivalent sessions this year. A western session will be held from June 6 to June 29 on the campus of Trinity University at San Antonio, Texas, and an eastern session, at Yale University in New Haven, Connecticut, from July 8 to August 5. The aim in holding two sessions is to make possible the accommodation of more students during the current year and at the same time to render attendance more convenient to students residing at great distances from New Haven.

The curriculum, consisting of lectures, seminars, and demonstrations, deals with the medical, psychological, physiological, psychiatric, sociological, economic, legal, religious, educational, and therapeutic aspects of alcohol problems. During the second half of each session, the curriculum is divided up into two parts for the professional groups concerned particularly with the educational or with the therapeutic aspects of alcoholism. The first half of each session is the same for all students.

The summer school is under the directorship of Professor E. M. Jellinek. The lecturers, mainly from the faculties of Yale University and Texas Christian University, include authorities who have done original research in their various fields as well as representatives of other national institutions of education, research, treatment, or rehabilitation. Most of the lectures at both the eastern and the western sessions will be given by the same faculty.

A Postgraduate Course in Psychiatry and Neurology at University of California Medical School

A postgraduate course of twelve weeks in psychiatry and neurology will be offered at the University of California Medical School (the Langley Porter Clinic), in San Francisco, August 29 through November 18, 1949, full time, under the chairmanship of Karl M. Bowman, M.D., professor of psychiatry, University of California. The fee will be $200. For program and information write to Stacy R. Mettier, M.D., Head of Postgraduate Instruction, Medical Extension, University of California Medical Center, San Francisco 22, California.

Examinations to Be Held for School Psychologists

The Board of Examiners of the Board of Education of New York City announces that it will conduct examinations early in the fall for the position of school psychologist and of supervisor of school psychologists. The salary ranges for these positions are: for school psychologist, $3,516 to $5,664 (maximum attainable after twelve years); for supervisor of school psychologists, $6,000. Salary credit

is granted for comparable service in other school systems and agencies.

Correspondence with respect to these examinations should be addressed to Board of Examiners, 110 Livingston Street, Brooklyn 2, N. Y., attention: Mr. Joseph Jablonower.

Recent Publications

Three pamphlets on the subject of the child and the nursery school have been issued by the New York Committee on Mental Hygiene, of the State Charities Aid Association. They are: *What Nursery School Is Like, How a Child Feels About Entering a Nursery Center,* and *The Child's First Days in Nursery School.* The first two are for parents; the third, for the nursery-school staff. They describe the equipment and activities of the nursery school, the feelings that a child may have in meeting this first experience away from home, and some of the steps that parents and teachers can take to help him make the adjustment.

The pamphlets may be obtained, at a price of 15 cents a copy, from the New York Committee on Mental Hygiene of the State Charities Aid Association, 105 East 22 St., New York 10, N. Y., or from The National Committee for Mental Hygiene.

Under the title *Human Relationships in Public Health,* the Commonwealth Fund, of New York, has issued a short report of the Institute on Mental Health in Public Health held in Berkeley, California, in the summer of 1948. The report, which is by Geddes Smith, describes briefly the procedures of the institute and summarizes the discussions. It should be of interest to all workers in the field of public health. Copies may be obtained, at 15 cents apiece, from the Commonwealth Fund, 41 East 57th Street, New York 22, N. Y.

CURRENT BIBLIOGRAPHY *

Compiled by

EVA R. HAWKINS
The National Health Library

Adelson, Edward T., M.D., Sugar, Carl, M.D. and Wortis, S. B., M.D. A sociopsychiatric study of twenty-five young offenders. American journal of psychiatry, 105:619–22, February 1949.

Albee, George W. Psychological concomitants of pulmonary tuberculosis. American review of tuberculosis, 18: 650–61, December 1948.

Aldrich, Charles A., M.D. Techniques for interesting a community in growth and development of children. Child development, 19:35–39, March–June 1948.

Allan, Frank N., M.D. and Kaufman, Manuel, M.D. Nervous factors in general practice. Journal of the American medical association, 138: 1135–38, December 18, 1948.

Allen, Frederick H., M.D. Aggression and emotional development. Understanding the child, 18:15, January 1949.

Altschule, Mark D., M.D. and Tillotson, K. J., M.D. The use of testosterone in the treatment of depressions. New England journal of medicine, 239:1036–38, December 30, 1948.

Alvarez, Walter C., M.D. What can the general practitioner do for the nervous patient? Journal of the Iowa state medical society, 39:43–50, February 1949.

Anderson, C. Woodroffe, M.B. Some aspects of the mental welfare of children and infants. Public health (London), 62:47–51, December 1948.

Anderson, Robert J., M.D. Tuberculosis in mental hospitals. (Editorial.) Public health reports, U. S. Public health service, 64:1–3, January 7, 1949.

Appel, Kenneth E. Psychiatry and human relations. Understanding the child, 18:3–8, January 1949.

Appelbaum, Emanuel, M.D., Dolgopol, V. B., M.D. and Dolgin, Joseph, M.D. Measles encephalitis. American journal of diseases of children, 77:25–48, January 1949.

Arieti, Silvano, M.D. Special logic of schizophrenic and other types of autistic thought. Psychiatry, 11: 325–38, November 1948.

Arsenian, John and Arsenian, J. M. Tough and easy cultures: a conceptual analysis. Psychiatry, 11: 377–85, November 1948.

Arzt, Philip K., M.D. Psychosomatic medicine in general practice. Journal-Lancet, 68:423–27, November 1948.

Auerbach, Aline B. Can mental hygiene books improve mental health? Child study, 26:39–40, 54–55, Spring, 1949.

Avery, Charlotte. Social competence of pre-school, acoustically handicapped children. Journal of exceptional children, 15:71–73, 88, December 1948.

Baer, Stanley and Baer, Betsy. The comics: a challenge to parents. National parent-teacher, 43:10–11, February 1949.

Bain, Katherine, M.D. Dissemination of information on child development by federal agencies. Child development, 19:52–66, March–June 1948.

Baker, Gladys S. I can learn to take care of myself—the case of Robert. Childhood education, 25:227–30, January 1949.

Baker, Sidney J. Speech disturbances: a case for a wider view of paraphasias. Psychiatry, 11:359–66, November 1948.

Bakwin, Harry, M.D. Enuresis in children. Journal of pediatrics, 34: 249–62, February 1949.

Bakwin, Harry, M.D. Pure maternal overprotection: maternal overaffection. Journal of pediatrics, 33: 788–94, December 1948.

Banen, David M., M.D. Doctor-patient relationship. Military surgeon, 104: 124–28, February 1949.

Barbara, Dominick A., M.D. A preliminary report of the value of pentothal sodium as a prognostic aid in 40 mental patients. Psychiatric quarterly, 22:418–27, July 1948.

Barber, Lucile. The caseworker promotes better understanding. Child

*** This bibliography is uncritical and does not include articles of a technical or clinical nature.**

welfare, Child welfare league of America, 27:12–14, November 1948.

Barhash, Abraham Z., M.D. Psychiatric contributions to community living. Child study, 26:41–42, 61–64, Spring, 1949.

Barhash, Abraham Z., M.D. and Bentley, M. C. Some thoughts arising from a preliminary survey of state programs. Mental hygiene, 33:40–50, January 1949.

Bartemeier, Leo H., M.D. The practical application of basic mental hygiene principles of the Cornelian corner. Mental hygiene bulletin, Michigan society for mental hygiene, 7:8–9, January 1949.

Baxter, Edna D. What is guidance? Childhood education, 25:202–5, January 1949.

Beaman, Florence N. Present day thinking in relation to behavior problems. Journal of exceptional children, 15:81–84, January 1949.

Bedell, Sullivan G., M.D. Insulin subshock in the treatment of anxiety states. Southern medical journal, 42:130–32, February 1949.

Beers, Dorothy H. Life in a day nursery. Child welfare, Child welfare league of America, 28:6–8, February 1949.

Bell, Eric Jr., M.D. and Karnosh, L. J., M.D. Tetra-ethyl ammonium chloride as an adjunct in treatment of psychovisceral manifestations of anxiety. Journal of nervous and mental disease, 108:367–72, November 1948.

Bennett, John W. The study of cultures: a survey of technique and methodology in field work. American sociological review, 13:672–89, December 1948.

Bergler, Edmund, M.D. Further studies on beating fantasies. Psychiatric quarterly, 22:480–86, July 1948.

Bergler, Edmund, M.D. Psychology of the killjoy. Medical record, 162: 11–12, January 1949.

Berman, Leo, M.D. Depersonalization and the body ego with special reference to the genital representation. Psychoanalytic quarterly, 17:433–52, October 1948.

Bettelheim, Bruno and Sylvester, Emmy, M.D. Milieu therapy—indications and illustrations. Psychoanalytic review, 36:54–68, January 1949.

Biber, Barbara. How can nursery school be expected to benefit a child? Journal of pediatrics, 34:112–19, January 1949.

Bice, Harry V. and Holden, M. G. D. Group counseling with mothers of children with cerebral palsy. Journal of social casework, 30:104–9, March 1949.

Billings, Edward G., M.D. The clinical importance of some normal attitudinal and ideological transitions of mid-life. American journal of psychiatry, 105:615–18, February 1949.

Bird, Brian, M.D. Social hygiene—a psychiatric viewpoint. Journal of social hygiene, 35:9–19, January 1949.

Bollmeier, Ludolf N., M.D. The dynamics of juvenile delinquency. Diseases of the nervous system, 10:53–55, February 1949.

Bonner, C. A., M.D. Mental hospital employees, their importance in future mental hospital betterment. American journal of psychiatry, 105: 669–72, March 1949.

Booker, Ivan A. Democracy in the teens. National parent-teacher, 43: 4–6, February 1949.

Bossard, James H. S. and Sanger, W. P. Children have insight, too. National parent-teacher, 43:27–28, January 1949.

Brill, Abraham A., M.D. In memoriam: Smith Ely Jelliffe, October 27, 1866–September 25, 1945. Psychoanalytic review, 35:343–49, October 1948.

Brockington, Colin F., M.D. Problem families. Journal of the Royal institute of public health and hygiene (London), 12:9–18, January 1949.

Brody, Celia. Fee charging—a dynamic in the casework process. Journal of social casework, 30:65–71, February 1949.

Brosin, Henry W., M.D. Psychiatry experiments with selection. Social service review, 22:461–68, December 1948.

Bruckner, Mrs. William T. Education for mental health. General federation clubwoman, General federation of women's clubs, 29:13–14, January 1949.

Buell, Frank A., M.D. and Biehl, J. P., M.D. The influence of hypnosis on the tremor of Parkinson's disease. Diseases of the nervous system, 10: 20–23, January 1949.

Burlingame, Clarence C., M.D. Psychosurgery—new help for the mentally ill. Scientific monthly, 68: 140–44, February 1949.

Burns, Eveline M. New forces in family living: economic trends. Journal of social casework, 30:50–55, February 1949.

Caldwell, John M., Jr., M.D. Current developments and problems in military neuropsychiatry. American

journal of psychiatry, 105:561–66, February 1949.

Cameron, Donald E., M.D. Facilitation and inhibition as factors in behavioral deviations. American journal of psychiatry, 105:693–96, March 1949.

Caprio, Frank S., M.D. A case of exhibitionism with special reference to the family setting. American journal of psychotherapy, 2:587–602, October 1948.

Carlson, Anton J., M.D. and Hirsh, Joseph. Chronic alcoholism—a public health problem. Health news, New York state department of health, 26: 3–5, 14–15, January 1949.

Cederquist, Helen T. The "good mother" and her children. Smith college studies in social work, 19: 1–26, October 1948.

Chapin, Amy B. Parent education for pre-school speech defective children. Journal of exceptional children, 15: 75–80, January 1949.

[Children need work and play] a collection of articles. Childhood education, 25:147–80, December 1948.

Christiansen, Phyllis K. To help children make friends. Childhood education, 25:221–22, January 1949.

Clark, Robert E. Psychoses, income, and occupational prestige. American journal of sociology, 54:433–40, March 1949.

Close, Kathryn. Apprenticeships for living. Survey, 85:35–38, 61–62, January 1949.

Clow, Hollis E., M.D. The outlook for patients admitted to a mental hospital after the age of sixty. New York state journal of medicine, 48: 2357–63, November 1, 1948.

Clow, Hollis E., M.D. and Allen, E. B., M.D. A study of depressive states in the aging. Geriatrics, 4:11–17, January–February 1949.

Cockerill, Eleanor. New emphasis on an old concept in medicine. Journal of social casework, 30:10–15, January 1949.

Coheen, Jack, M.D. Follow-up studies of patients with pre-frontal lobe lobotomy. Illinois medical journal, 94:366–68, December 1948.

Cohen, R. R., M.D. and Ebaugh, F. G., M.D. Place of psychiatry in the industrial team. Occupational medicine, 5:522–29, May 1948.

Collins, Gretchen. A guidance program in action. Childhood education, 25: 223–27, January 1949.

Conn, Jacob H., M.D. Hypno-synthesis; hypnosis as a unifying interpersonal experience. Journal of nervous and mental disease, 109:9–24, January 1949.

Corey, Stephen M. and Madigan, V. E. Dissemination of child development information through the use of motion pictures. Child development, 19:93–111, March–June 1948.

Coulter, Charles W. Family disorganization as a causal factor in delinquency and crime. Federal probation, 12:13–17, September 1948.

Csillag, I. and Hedri, E. Personal factors of accident proneness. Industrial medicine, 18:29–30, January 1949.

Cunningham, Ruth and others. Johnny doesn't belong. Fourth in a series of articles on group dynamics in education. NEA journal, National education association, 37:578–79, December 1948.

Cutts, Norma E. and Moseley, Nicholas. Classroom teachers can help maladjusted children. Journal of exceptional children, 15:71–74, January 1949.

Danziger, Lewis, M.D. Entropy, mental disease and death. Diseases of the nervous system, 10:35–47, February 1949.

Davidson, William E., Jr. A positive approach to the control of crime. Federal probation, 12:21–23, September 1948.

Davis, Ruth G. Group therapy and social acceptance in a first-second grade. Elementary school journal, 49:219–23, December 1948.

Dawe, H. C., Ekern, Dorothy and Berger, Harriet. Differences in adult contacts with children. Journal of home economics, 41:87–88, February 1949.

Dawson, Elizabeth. Australian child guidance clinics. Understanding the child, 18:17–18, January 1949.

Diethelm, Oskar, M.D. The evaluation of a psychiatric examination. American journal of psychiatry, 105: 606–11, February 1949.

Doan, D. I., M.D. and Huston, P. E., M.D. Electric shock during pregnancy; a report of seven cases. Psychiatric quarterly, 22:413–17, July 1948.

Dobbs, Harrison A. Social service for probationers and parolees. Focus, National probation and parole association, 28:7–12, January 1949.

Drake, Frank R., M.D. Religion and psychiatry. American journal of the medical sciences, 217:111–16, January 1949.

Dribben, Irving S. Psychosis following "amateur hypnosis," a case report.

Military surgeon, 104:136–37, February 1949.

Dunkel, Mary L. Casework help for neurodermatitis patients. Journal of social casework, 30:97–103, March 1949.

Ellingston, John R. Protecting our children from criminal careers. Federal probation, 12:34–37, September 1948.

English, Oliver S., M.D. Psychological factors in everyday practice. Rocky Mountain medical journal, 46:21–26, January 1949.

Erickson, Milton H., M.D. Psychological significance of physical restraint to mental patients. American journal of psychiatry, 105:612–14, February 1949.

Eustis, Richard S., M.D. Right- or left-handedness: a practical problem. New England journal of medicine, 240:249–53, February 17, 1949.

Evans, W. N. The cultural significance of the changed attitude toward work in Great Britain. Bulletin, Menninger clinic, 13:1–8, January 1949.

Fay, Temple, M.D. and Doll, E. A. Organic impairment simulating mental deficiency. American journal of orthopsychiatry, 19:112–19, January 1949.

Fitch, Florence M. Thumbs down on prejudice. National parent-teacher, 43:21–23, February 1949.

FitzGerald, G. W., M.D. Neuropsychiatry and medicine. Canadian medical association journal (Montreal), 60:125–29, February 1949.

Font, Marion M. Some exceptional children go home to exceptional parents. Journal of exceptional children, 15:80–82, 88, December 1948.

Fox, Vernon. Classification in a minimum security institution. Journal of criminal law and criminology, 39: 471–79, November–December 1948.

Foxe, Arthur N., M.D. A brief passage. Psychoanalytic review, 35: 364–66, October 1948.

Freeman, Walter, M.D. Psychosurgery: retrospects and prospects based on twelve years' experience. American journal of psychiatry, 105:581–84, February 1949.

French, L. C., M.D. Alcoholic ward poses no special problem. Modern hospital, 72:75–76, January 1949.

Freud, Anna. Nursery school education—its uses and dangers. Child study, 26:35–36, 58–60, Spring, 1949.

Friedman, Arnold P., M.D., Brenner, Charles, M.D. and Carter, Sidney, M.D. Symptomatic treatment of certain types of chronic headache. Journal of the American medical association, 139:195–98, January 22, 1949.

Friedman, Paul, M.D. Some aspects of concentration camp psychology. American journal of psychiatry, 105: 601–5, February 1949.

Froeschels, Emil, M.D. A peculiar intermediary state between waking and sleeping. American journal of psychotherapy, 3:19–25, January 1949.

Gabower, Genevieve. Notes on dealing with delinquency in Italy. Focus, National probation and parole association, 28:1–6, 18–20, January 1949.

Gardner, George E. The community and the aggressive child. Understanding the child, 18:16, January 1949.

Geisel, Winifred M. The psychiatric nurse in the community. American journal of nursing, 49:23–24, January 1949.

Geoghegan, John J., M.D. and Stevenson, G. H., M.D. Prophylactic electroshock. American journal of psychiatry, 105:494–96, January 1949.

Gibbs, Frederic A., M.D., Everett, G. M. and Richards, R. K., M.D. Phenurone in epilepsy. Diseases of the nervous system, 10:47–49, February 1949.

Gillin, John. Magical fright. Psychiatry, 11:387–400, November 1948.

Gladstone, Roy. Do maladjusted teachers cause maladjustment? Journal of exceptional children, 15:65–70, December 1948.

Gleason, Marion N. The accident-prone patient. New York state journal of medicine, 48:2168–70, October 1, 1948.

Goldsmith, Maurice. Mental health. Hygeia, 27:40–41, 54, January 1949.

Goodrich, Frederick W., Jr., M.D. Natural childbirth. Child study, 26: 51–53, Spring, 1949.

Gottlieb, Jacques S., M.D. The use of sodium amytal and benzedrine sulfate in the symptomatic treatment of depressions. Diseases of the nervous system, 10:50–52, February 1949.

Gray, Horace, M.D. Bibliography of Freud's pre-analytic period. Psychoanalytic review, 35:403–10, October 1948.

Gray, Horace, M.D. Freud and Jung: their contrasting psychological types. Psychoanalytic review, 36:22–44, January 1949.

Gray, William, M.D. Group psychotherapy in a state hospital. Journal of nervous and mental disease, 108: 485–95, December 1948.

Greco, Marshall C. Socioanalysis: a new approach to crimonology. Focus,

National probation and parole association, 28:13–18, January 1949.

Greenberg, Harold A., M.D. The emotional problems and education of hospitalized children. Journal of pediatrics, 34:213–18, February 1949.

Griffin, Daniel P., M.D. Psychosomatic medicine and the occupational therapist. Connecticut state medical journal, 12:923–27, October 1948.

Grossbard, Hyman. Relative values of legal and voluntary commitments of children to institutions. Child welfare, Child welfare league of America, 27:6–9, November 1948.

Group therapy—Round table, 1948. H. M. Little, M.D., chairman. American journal of orthopsychiatry, 19: 56–86, January 1949.

1. Knowledge and skill of the group therapist, by Gisela Konopka.—2. Interpretation of group therapy to parents, by M. E. Brennan and Maxine Steinitz.—3. Group work with psychotic veterans, by Bernice Perlman.—4. Rhythmic activity—a project in group therapy with children, by Phyllis Van Vleet.

Gundry, Charles H., M.D. Industrial psychiatry. Canadian journal of public health (Toronto), 40:7–12, January 1949.

Günzburg, H. C. The unsuccessful reader. Mental health, National association for mental health (London), 8:34–37, November 1948.

Haber, Sidney, M.D., Paley, Aaron, M.D. and Block, A. S., M.D. Treatment of problem drinkers at Winter veterans administration hospital. Bulletin, Menninger clinic, 13:24–30, January 1949.

Hamilton, Samuel W., M.D. What psychiatric service should general hospital have? Hospital management, 66:29–31, December 1948. (To be concluded.)

Hannell, Charlotte L. Helping children move into adoptive homes. Child welfare, Child welfare league of America, 28:9, 12–14, January 1949.

Hannett, Frances, M.D. Transference reactions to an event in the life of the analyst. Psychoanalytic review, 36:69–81, January 1949.

Hansburg, Henry. The case of "Arthur." Understanding the child, 18: 24–27, January 1949.

Hart, Henry H., M.D. The eye in symbol and symptom. Psychoanalytic review, 36:1–21, January 1949.

Hart, Henry H., M.D. Sublimation and aggression. Psychiatric quarterly, 22:389–412, July 1948.

Hartwell, Samuel W., M.D. The guidance clinic and the court. Federal probation, 12:3–7, September 1948.

Hattwick, LaBerta A. Little fidgets have big needs. National parent-teacher, 43:7–9, November 1948.

Hawley, Paul R., M.D. Extramural medical care and the national resources. American journal of psychiatry, 105:481–84, January 1949.

Haynes, F. E. The sociological study of the prison community. Journal of criminal law and crimonology, 39: 432–40, November–December 1948.

Henderson, Adele. The nurse in a mental health clinic. Public health nursing, 41:42–45, January 1949.

Henderson, Peter, M.D. Epilepsy in children. Journal of the Royal institute of public health and hygiene (London), 11:369–77, November 1948.

Hildreth, Gertrude. Quarreling among children. National parent-teacher, 43:7–9, February 1949.

Hinkle, Lawrence E., Jr., M.D. and Wolf, Stewart, M.D. Experimental study of life situations, emotions, and the occurrence of acidosis in a juvenile diabetic. American journal of the medical sciences, 217:130–35, February 1949.

Hitschmann, Edward, M.D. and Bergler, Edmund, M.D. Frigidity in women—restatement and renewed experiences. Psychoanalytic review, 36:45–53, January 1949.

Höjer, J. A., M.D. The importance of the coöperation of physicians in the attack on alcoholism. Quarterly journal of studies on alcohol, 9:363–71, December 1948.

Hollander, Abe A. Temper and how to handle it. Parents' magazine, 24: 24–25, 122, February 1949.

Howe, Quincy. Perspective on national health planning. Mental hygiene, 33: 61–70, January 1949.

A hundred-year round-up in mental health. Better health, North Carolina social hygiene society, 3:12–13, 20, 22, January 1949.

Hurley, Beatrice J. The handicapped child is a person. Understanding the child, 18:9–12, January 1949.

Immediate retrospects on the I.P.C. [International preparatory commission]. Psychiatry, 11:339–44, November 1948.

Impallaria, Constance. Social group work at the Pittsburgh child guidance center. Federator, Federation of social agencies of Pittsburgh and Allegheny county, 23:8–11, December 1948.

Jelliffe, Smith E., M.D. The ecological principle in medicine. Psychoana-

lytic review, 35:367–88, October 1948.

Jenkins, Gladys G. Character begins at home. Parents' magazine, 24: 36–37, 81–83, February 1949.

Johnson, Charles S. New forces in family living: social reorientation. Journal of social casework, 30:47–50, February 1949.

Jones, Howard. Group sentiment and delinquency. Mental health, National association for mental health (London), 8:41–44, November 1948.

Jones, Robert O., M.D. Depressive reactions: their importance in clinical medicine. Canadian medical association journal (Montreal), 60:44–48, January 1949.

Josselyn, Irene M., M.D. Emotional implications of rheumatic heart disease in children. American journal of orthopsychiatry, 19:87–100, January 1949.

Kalinowsky, Lothar B., M.D. Variations of body weight and menstruation in mental illness and their relation to shock treatments. Journal of nervous and mental disease, 108:423–30, November 1948.

Kallmann, Franz J., M.D. Applicability of modern genetic concepts in the management of schizophrenia. Journal of heredity, 39:339–44, November 1948.

Karlan, Samuel C., M.D. and Heller, Eugene. Post-traumatic syndrome. Psychiatric quarterly, 22:487–94, July 1948.

Kavinoky, Nadina R., M.D. The physician and the medical aspects of the National conference on family life. Medical woman's journal, 55:46–53, December 1948.

Kawin, Ethel. How intelligence develops. National parent-teacher, 43: 11–13, January 1949.

Keliher, Alice V. Childhood and the democratic future. NEA journal, National education association, 37: 590–91, December 1948.

Keliher, Alice V. Wanted—a symphony of services. Survey, 85:54–55, January 1949.

Kendall, Glenn M. The New York state reception center. Federal probation, 12:42–47, September 1948.

Kersten, Paul M., M.D. Amateur radio and occupational therapy. Occupational therapy and rehabilitation, 27:498–502, December 1948.

Kindwall, Josef A., M.D. Carbon-dioxide narcosis therapy. American journal of psychiatry, 105:682–85, March 1949.

Klein, Alexander. He lets them grow: the story of the children's friend, "Slavie," and how he developed a new method which solves behavior problems in warped young lives. Survey, 85:75–80, February 1949.

Klein, Eva, M.D. The treatment of alcoholism: a case history. American journal of psychotherapy, 3: 74–85, January 1949.

Klein, George S. Adaptive properties of sensory functioning: some postulates and hypotheses. Bulletin, Menninger clinic, 13:16–23, January 1949.

Klein, Henriette R., M.D. and Horwitz, W. A., M.D. Psychosexual factors in the paranoid phenomena. American journal of psychiatry, 105:697–701, March 1949.

Knight, Robert P., M.D. A critique of the present status of the psychotherapies. Bulletin, New York academy of medicine, 25:100–14, February 1949.

Knight, Robert P., M.D. "The shame of the states": A discussion of Albert Duetsch's study on state mental hospitals. Trained nurse and hospital review, 122: 62–65, February 1949.

Korson, Selig M., M.D. The successful treatment of an obsessive compulsive neurosis with narcosynthesis followed by daily electro-shocks. Journal of nervous and mental disease, 109:37–41, January 1949.

Kris, Ernst. Prince Hal's conflict. Psychoanalytic quarterly, 17:487–506, October 1948.

Kubie, Lawrence S., M.D. Problems parents can prevent. Child study, 26:37–38, 56–57, Spring, 1949.

Landis, Carney. Experimental methods in psychopathology. Mental hygiene, 33:96–107, January 1949.

Lang, H. B., M.B. You—and the alcoholic. Mental hygiene news, New York state department of mental hygiene, 19:3, 9, January 1949.

Lauterbach, Albert. Economics and psychiatry: an economist's point of view. (Abstract.) American journal of psychotherapy, 3:117–19, January 1949.

Lawson, Frederick S., M.D. Psychiatric developments in Saskatchewan—hospitals. Canadian medical association journal (Montreal), 59:549–50, December 1948.

Lavarsfeld, Sofie. The use of fiction in psychotherapy. (A contribution to bibliotherapy.) American journal of psychotherapy, 3:26–33, January 1949.

Lee, Harry B., M.D. Projective features of contemplative artistic ex-

perience. American journal of orthopsychiatry, 19:101–11, January 1949.

Lee, Harry B., M.D. Spirituality and beauty in artistic experience. Psychoanalytic quarterly, 17:507–23, October 1948.

Lee, John P. Clinic for alcoholics—makes friends and influences patients. Modern hospital, 71:68–69, December 1948.

Leighton, Alexander H., M.D. Dynamic forces in international relations. Mental hygiene, 33:17–24, January 1949.

Levinrew, George E. Special school services for children with epilepsy. Journal of exceptional children, 15: 66–70, January 1949.

Levy, David M., M.D. Projective techniques in clinical practice. American journal of orthopsychiatry, 19:140–44, January 1949.

Lewin, Bertram D., M.D. The nature of reality, the meaning of nothing, with an addendum on concentration. Psychoanalytic quarterly, 17:524–26, October 1948.

Lewis, John B. S., M.D. Training and scope of psychiatric social workers in relation to adults. Mental health, National association for mental health (London), 8:38–41, November 1948.

Lewis, Nolan D. C., M.D. Criteria for early differential diagnosis of psychoneurosis and schizophrenia. American journal of psychotherapy, 3:4–18, January 1949.

Lewis, Nolan D. C., M.D. Dr. Abraham A. Brill as a psychiatrist. Psychoanalytic review, 35:399–402, October 1948.

Lewis, Nolan D. C., M.D. Psychosomatic principles and patterns in disorders of the special senses. Psychoanalytic review, 35:411–39, October 1948.

Liebman, Samuel, M.D. and French, R. L. Patient population distribution in mental hospitals in the United States. American journal of psychiatry, 105:489–93, January 1949.

Lindner, Robert M. The equivalents of matricide. Psychoanalytic quarterly, 17:453–70, October 1948.

Line, William. Mental hygiene in industry. Psychiatry, 11:367–70, November 1948.

Linn, Louis, M.D. and Ottenheimer, J. G., M.D. Cardiac complications in electroshock therapy. Diseases of the nervous system, 10:8–10, January 1949.

Lipton, Harry R., M.D. The psychopath in prison. Military surgeon, 104:119–23, February 1949.

Little, Ruby. Diagnostic recording. Journal of social casework, 30:15–19, January 1949.

Little, Sherman, M.D. The function of a child guidance clinic in a children's hospital. New York state journal of medicine, 48:2379–81, November 1, 1948.

Lorand, Sandor, M.D. On the meaning of losing teeth in dreams. Psychoanalytic quarterly, 17:529–30, October 1948.

Lourie, Reginald S., M.D. The rôle of rhythmic patterns in childhood. American journal of psychiatry, 105: 653–60, March 1949.

Lowrey, James V., M.D. How the National mental health act works. Mental hygiene, 33:30–39, January 1949.

Luchins, Abraham S. The rôle of the social field in psychotherapy. Journal of consulting psychology, 12: 417–25, November–December 1948.

Luehrs, Leslie E., M.D. The venereal disease patient as a delinquent. Journal of social hygiene, 35:26–33, January 1949.

Lundberg, George A. Human social problems as a type of disequilibrium in a biological integration. American sociological review, 13:689–99, December 1948.

Lyle, Leon R. Placing older children for adoption. Child welfare, Child welfare league of America, 28:3–8, January 1949.

McClusky, Howard Y. Dissemination of child development knowledge through a program of adult education and community action. Child development, 19:40–51, March–June 1948.

McGuire, Carson and Smith, S. B. Child development in periodical literature. Child development, 19:112–24, March–June 1948.

McKeown, James E. Poverty, race and crime. Journal of criminal law and criminology, 39:480–84, November–December 1948.

McKerracher, Donald G., M.D. Community psychiatric developments in Saskatchewan. Canadian medical association journal (Montreal), 59: 546–48, December 1948.

MacKinnon, Irville H., M.D. and others. The use of malononitrile in the treatment of mental illnesses; preliminary report. American journal of psychiatry, 105:686–88, March 1949.

Maholick, L. T., M.D. and Warkentin, J., M.D. Hypnosis in electric shock treatment. American journal of psychiatry, 105:623, February 1949.

Malamud, William, M.D. and others. The involutional psychoses: a socio-psychiatric follow-up study. American journal of psychiatry, 105:567–72, February 1949.

Malzberg, Benjamin. A statistical study of patients in the New York civil state hospitals, April 1, 1947. Psychiatric quarterly, 22:495–515, July 1948.

Mann, James, M.D. Human relations in public health nursing. Public health nursing, 40:583–88, December 1948.

Marcussen, Robert M., M.D. and Wolff, H. G., M.D. Therapy of migraine. Journal of the American medical association, 139:198–200, January 22, 1949.

Margolis, Harry M., M.D. The biodynamic point of view in medicine. Journal of social casework, 30:3–9, January 1949.

Mautner, Helene. The psychiatric worker in rural Michigan. Journal of rehabilitation, 14:8–11, 16, December 1948.

Mead, Margaret. The International preparatory commission of the London conference on mental hygiene. Mental hygiene, 33:9–16, January 1949.

Meduna, Ladislas J., M.D. Alteration of neurotic pattern by use of CO_2 inhalations. Journal of nervous and mental disease, 108:373–79, November 1948.

Menninger, Karl A., M.D. The doctor as a leader. Bulletin, Menninger clinic, 13:9–15, January 1949.

Menninger, Karl A., M.D. and Devereux, George. Smith Ely Jelliffe—father of psychosomatic medicine in America. Psychoanalytic review, 35:350–63, October 1948.

Menninger, William C., M.D. Calling all fathers. Parents' magazine, 24: 26, 50, February 1949.

Menninger, William C., M.D. Research in mental health in the national perspective. Mental hygiene, 33:78–95, January 1949.

Merrill, Bruce, M.D. A note on the architecture of the psychiatric ward. American journal of psychiatry, 105: 691–92, March 1949.

Meyer, Mrs. Eugene. The social responsibilities of the scientists for child care. Child development, 19: 9–14, March–June 1948.

Miller, C. A., M.D. and Lennox, M. A., M.D. Electroencephalography in behavior problem children. Journal of pediatrics, 33:753–60, December 1948.

Mohr, Jennie. Home-making problems of working women. Smith college studies in social work, 19:27–62, October 1948.

Monash, Louis. Mental hygiene and preventive discipline. Mental hygiene news, New York state department of mental hygiene, 19:5, 9, December 1948.

Monash, Louis. Notes on mental hygiene and preventive discipline. Understanding the child, 18:19–23, January 1949.

Montgomery, John C., M.D. Opportunities to influence parent-child relationships — "rooming-in." Medical woman's journal, 55:24–26, December 1948.

Moorman, Robert, Jr., The spiritual concept in alcoholic therapy. Scientific temperance journal, 56:71–79, Autumn 1948.

Morgan, Edith E. Psychiatric nurses misrepresented in movie. "The snake pit" will win awards, but does not do justice to nursing. Trained nurse and hospital review, 122:59–61, February 1949.

Morris, Don P., M.D. Some psychiatric aspects of cardiovascular disease. Diseases of the nervous system, 10: 11–14, January 1949.

Murphy, Douglas P., M.D. Mental deficiency from the viewpoint of the obstetrician. American journal of orthopsychiatry, 19:120–24, January 1949.

Nathan, Cynthia R. Clinic casework in a mass tuberculosis survey. Journal of social casework, 30:92–97, March 1949.

Nattrass, Frederick J., M.D. Clinical and social problems of epilepsy. British medical journal (London), p. 1–6, January 1, 1949; p. 43–48, January 8, 1949.

Nussbaum, Kurt, M.D. and Charen, Sol. Out-patient treatment of pre-psychotic and post-psychotic veterans in a mental hygiene clinic. Psychiatric quarterly, 22:516–35, July 1948.

Nussbaum, Schymen, M.D. Eclectic psychotherapy. Diseases of the nervous system, 10:28–29, January 1949.

Oberndorf, Clarence P., M.D. New possibilities in private psychiatric practice. American journal of psychiatry, 105:589–93, February 1949.

Oberndorf, Clarence P., M.D. Obituary: Dr. Abraham Arden Brill. Psychoanalytic review, 35:389–93, October 1948.

O'Doherty, Eamonn F. Multidisciplinary methods in retrospect. Psychiatry, 11:355–58, November 1948.

Oechsli, Waldo R., M.D. Tuberculosis control program of nine California mental institutions. Public health

reports, U. S. Public health service, 64:4–16, January 7, 1949.

"Official" retrospect on the I.P.C. [International preparatory commission]. Psychiatry, 11:345–48, November 1948.

Ojemann, Ralph H. and others. A functional analysis of child development material in current newspapers and magazines. Child development, 19:76–92, March–June 1948.

Orthopsychiatry 1923–1948: retrospect and prospect. By Sol W. Ginsburg, M.D. and others. American journal of orthopsychiatry, 19:147–51, January 1949.

Overholser, Winfred, M.D. Physical medicine and psychiatry, some interrelationships. Journal of the American medical association, 138:1221–22, December 25, 1948.

Overstreet, Bonaro W. The high art of belonging. Parts II–VI. National parent-teacher, 43:10–12, October 1948; 19–21, November 1948; 10–12, December 1948; 8–10, January 1949; 24–26, February 1949.

Pacella, Bernard L., M.D. Electronarcosis in psychiatric therapy. New York state journal of medicine, 48: 2387–89, November 1, 1948.

Papez, James W., M.D. and Smolen, E. M., M.D. Self-inflicted prefrontal lobotomy: a case report. Journal of nervous and mental disease, 108: 477–84, December 1948.

Parsons, Jack R. Changing use of children's institutions. Child welfare, Child welfare league of America, 27: 3–7, December 1948.

Perls, Frederick S., M.D. Theory and technique of personality integration. American journal of psychotherapy, 2:565–86, October 1948.

Pescor, Michael J., M.D. A study of selective service law violators. American journal of psychiatry, 105:641–52, March 1949.

Petree, Paul A., M.D. Psychiatric disorders resulting from beverage alcohol. Scientific temperance journal, 56:80–93, Autumn 1948.

Pleasure, Hyman, M.D. Tuberculosis in a state hospital: A practical program with five-year follow-up. Psychiatric quarterly, 22:445–61, July 1948.

Pope, Elizabeth. Changes in parental attitudes; an interview with Sidonie Matsner Gruenberg. Child study, 26: 43–44, Spring, 1949.

Pratt, Dallas, M.D. Public mental hospitals in England: a survey. American journal of psychiatry, 105:485–88, January 1949.

Prescott, Daniel A. Communicating knowledge of children to teachers. Child development, 19:15–24, March–June 1948.

Presentation of the Lasker award in mental hygiene. Mental hygiene, 33: 123–24, January 1949.

Prevey, Esther E. Children need parents. Childhood education, 25:206–9, January 1949.

Psychiatric factors in social hygiene problems. (Editorial.) Journal of social hygiene, 35:7–8, January 1949.

Querido, Arie, M.D. Notes on an experiment in international multiprofessional coöperation. Psychiatry, 11:349–54, November 1948.

Ramsey, Glenn V. and Seipp, Melita. Attitudes and opinions concerning mental illness. Psychiatric quarterly, 22:428–44, July 1948.

Rank, Beata. Adaptation of the psychoanalytic technique for the treatment of young children with atypical development. American journal of orthopsychiatry, 19:130–39, January 1949.

Ransone, John T., M.D. Pre-occupation with painful memories as basis for neurosis and physical illness. Virginia medical monthly, 76:79–82, February 1949.

The red plague (Stalin's Treponema rufum)—a new public health problem. (Editorial.) Psychiatric quarterly, 22:548–59, July 1948.

Rees, John R., M.D. The International congress on mental health, London, August 11th to 21st, 1948. Mental health, National association for mental health (London), 8:44–45, November 1948.

Reese, Justin G. We can eliminate the shame of the states. Minnesota welfare, 4:6–8, December 1948.

Reinemann, John O. The truant before the court. Federal probation, 12: 8–12, September 1948.

The relationship between religion and psychotherapy in the adjustment of the individual. Symposium. Journal of psychiatric social work, 18: 59–80, Autumn 1948.

I. The problem of coöperation between the psychotherapist and the spiritual advisor, by Walter Kluge.—II. Christianity and psychotherapy: conflict or coöperation? by O. R. Rice.—III. Catholic point of view on the relationship between religion and psychotherapy in the adjustment of the individual, by R. M. Bédard.—IV. Concluding statement on the relationship of religion and psychotherapy in the adjustment of the individual, by L. E. Woodward.

Review of psychiatric progress 1948. American journal of psychiatry, 105: 497–547, January 1949.

Reynolds, Rosemary, Powell, A. S. and Zelditch, Morris. Symposium: casework and the aging population. Journal of social casework, 30:58–65, February 1949.

Richards, Esther L., M.D. Social aspects of the alcohol problem in community life. Scientific temperance journal, 56:67–70, 93–96, Autumn 1948.

Ridenour, Nina. Community education through press, radio, films and drama. Mental hygiene, 33:71–77, January 1949.

Riggs, Vincent J., M.D. Modified electro-shock therapy and rapid treatment of mental illness. Journal of the Medical society of New Jersey, 45:521–23, November 1948.

Robinson, Joseph F., M.D. What are the trends in child-guidance clinics? Child, U. S. Children's bureau, 13: 86–88, 93, December 1948.

Robinson, Robert L., and Freeman, Lorne. Report on the APA information service. American journal of psychiatry, 105:710–13, March 1949.

Róheim, Géza. The thread of life. Psychoanalytic quarterly, 17:471–86, October 1948.

Ross, Helen. Freedom from fear. National parent-teacher, 43:7–9, December 1948.

Ross, Helen. New forces in family living: emotional values. Journal of social casework, 30:55–58, February 1949.

Ross, Helen and Johnson, A. M., M.D. Psychiatric interpretation of the growth process. Part I. The earliest years. Journal of social casework, 30:87–92, March 1949.

Ross, Mabel, M.D. Mental health congress looks at the family. Journal of home economics, 41:71–73, February 1949.

Rumsey, H. St. J. Speech therapy: stammering treatment—supply and demand. Journal of the Royal institute of public health and hygiene (London), 11:399–402, December 1948.

Rymer, Charles A., M.D. The insanity plea in crime: an evaluation of the 1927 law. American journal of psychiatry, 105:594–600, February 1949.

Sackheim, Gertrude. Suggestions on recording techniques. Journal of social casework, 30:20–25, January 1949.

Safier, Benno, M.D. and others. A psychiatric approach to the treatment of promiscuity. [Excerpts from a forthcoming report from the San Francisco psychiatric clinic.] Journal of social hygiene, 35:20–25, January 1949.

Sands, Irving J., M.D. Frontal lobotomy. Public health nursing, 41: 102–3, February 1949.

Santos, Elvin H. and Stainbrook, Edward, M.D. Nursing and modern psychiatry. American journal of nursing, 49:107–9, February 1949.

Scheele, Leonard A., M.D. General principles of the federal program for mental hygiene. Mental hygiene, 33:25–29, January 1949.

Schmidl, Fritz. On contact with the second partner in marriage counseling. Journal of social casework, 30: 30–36, January 1949.

Schmidt, Bernardine G. Development of social competencies in adolescents originally classified as feebleminded. American journal of orthopsychiatry, 19:125–29, January 1949.

Schneck, Jerome M., M.D. Sleep paralysis; psychodynamics. Psychiatric quarterly, 22: 462–69, July 1948.

Schneider, Kurt. Current trends in German psychiatry. American journal of psychiatry, 105:689–90, March 1949.

Schwartz, Louis A., M.D. Paget's disease in three male siblings. Journal of the Michigan state medical society, 47:1244–47, November 1948.

Sears, Robert R. Radio and journalism in the dissemination of child development information. Child development, 19:25–34, March–June 1948.

Seliger, Robert V., M.D. Commandments for the abnormal drinker. Mental hygiene news, New York state department of mental hygiene, 19:4, January 1949.

Seliger, Robert V., M.D. Correctional psychology. Federal probation, 12: 38–41, September 1948.

Seliger, Robert V., M.D. Medical psychological aspects of contemporary alcoholism. Journal of criminal law and criminology, 39:425–31, November–December 1948.

Sellery, Clarence M., M.D. An organized mental-hygiene program in the schools. NEA journal, National education association, 37:586–88, December 1948.

Shaw, Franklin J. Some postulates concerning psychotherapy. Journal of consulting psychology, 12:426–31, November–December 1948.

Siebold, Janet. Helping new Americans. Journal of social casework, 30:71–77, February 1949.

Simon, Abraham J. Cottage parent and caseworker—a team. Child wel-

fare, Child welfare league of America, 28:3–6, February 1949.

Sivadon, Paul. Rehabilitation of psychiatric patients after hospital discharge. Occupational therapy and rehabilitation, 27:479–91, December 1948.

Slear, Genevieve S. Transition from caseworker to supervisor. Journal of social casework, 30:25–30, January 1949.

Slobe, Frederick W., M.D. The epileptic in industry. (Editorial.) Industrial medicine, 18:45–46, January 1949.

Sobel, Frances S. Remedial teaching as therapy. American journal of psychotherapy, 2:615–23, October 1948.

Solomon, Alfred P., M.D. Low back pain: the psychosomatic viewpoint—a preliminary report. Industrial medicine, 18:6–12, January 1949.

Somerfeld-Ziskind, Esther, M.D. Group therapy. Medical woman's journal, 56:24–29, January 1949.

Spencer, Lyle. Your child's abilities: how to understand and develop them. General federation clubwoman. General federation of women's clubs, 29: 4–6, 27, February 1949.

Stekel, Wilhelm, M.D. Autobiography (VII–VIII). American journal of psychotherapy, 2:624–49, October 1948; 3:46–73, January 1949.

Stendler, Celia B. Building secure children in our schools. Childhood education, 25:216–20, January 1949.

Stephens, Gordon. Psychiatric problems in the educational sphere. Understanding the child, 18:13–14, January 1949.

Stern, Adolph, M.D. Transference in borderline neuroses. Psychoanalytic quarterly, 17:527–28, October 1948.

Stern, Edith M. Stepchildren of the community: the feebleminded. Mental hygiene bulletin, Michigan society for mental hygiene, 7:1–5, January 1949.

Stevenson, George S., M.D. The National committee for mental hygiene looks ahead. Mental hygiene, 33: 1–8, January 1949.

Stokes, A. B., M.B. Old age from the psychiatric viewpoint. Canadian medical association journal (Montreal), 59:518–21, December 1948.

Stone, Simon, M.D. Electroshock therapy in depressive states: experience in a general hospital. New England journal of medicine, 240:203–7, February 10, 1949.

Strang, Ruth. The truth about report cards. National parent-teacher, 43: 4–7, January 1949.

Stürup, Georg K., M.D. The management and treatment of psychopaths in a special institution in Denmark. Proceedings of the Royal society of medicine, Section of psychiatry (London), 41:765–68, November 1948.

Sullivan, Harry S., M.D. Psychiatry, education, and the UNESCO "tensions project." Psychiatry, 11:371–75, November 1948.

Suratt, Theodore P., M.D. Combat psychiatry in an infantry division. Psychiatric quarterly, 22:536–47, July 1948.

Symonds, Percival M. Implications of fantasy for education. Elementary school journal, 49:273–77, January 1949.

Terhune, William B., M.D. Religion and psychiatry. Journal of pastoral care, 2:15–21, Fall 1948.

Terhune, William B., M.D. and Dickenson, J. R., M.D. Progress in group psychotherapy: a summary of the literature. New England journal of medicine, 239:854–57, December 2, 1948.

Thielbar, Frances C. Research in psychiatric nursing. Mental hygiene, 33:115–22, January 1949.

Thompson, Lloyd J., M.D. Characteristics of headache in anxiety and hysterical reactions. North Carolina medical journal, 9:606–8, December 1948.

Towle, Charlotte. Case-work methods of helping the client to make maximum use of his capacities and resources. Social service review, 22: 469–79, December 1948.

Tracht, Vernon S. Preliminary findings on testing the cerebral palsied with Raven's 'Progressive matrices.' Journal of exceptional children, 15: 77–79, 89, December 1948.

Trager, Helen and Radke, Marian. Guidance for human relations education. Childhood education, 25: 210–15, January 1949.

Training for psychotherapy with special reference to nonmedical fields. Symposium, 1948. American journal of orthopsychiatry, 19:1–55, January 1949.

1. Presidential address, by M. E. Kirkpatrick, M.D.—2. The distinctive area of social work in orthopsychiatry, by Almena Dawley.—3. The Training of case workers in psychotherapy, by N. W. Ackerman, M.D.—4. The training of psychiatric social workers for individual psychotherapy, by Frederika Neumann.—5. The evolution of the clinical psychologist, by Morris Krugman.—6. Problems in-

volved in the training of psychologists as nonmedical psychotherapists, by A. G. Woltman.—7. Remarks on training for psychotherapy, by S. A. Szurek, M.D.—8. Discussion.

Treuting, Theodore F., M.D. and Ripley, H. S., M.D. Life situations, emotions and bronchial asthma. Journal of nervous and mental disease, 108: 380–98, November 1948.

Turnbull, Frank, M.D. and Davidson, Allan, M.D. Experience with leucotomy at the Provincial mental hospital, British Columbia. Canadian medical association journal (Montreal), 60:130–33, February 1949.

Tweed, A. R., M.D. Two cases of bromide psychosis simulating an involutional paranoid. American journal of psychotherapy, 2:650–57, October 1948.

Tyler, J. E., M.D. Objectives of the Arkansas mental hygiene program. Arkansas health bulletin Arkansas state board of health, 5:3–5, 7, December 1948.

Van de Water, Marjorie. Problems faced by a writer in communicating research findings in child development. Child development, 19:67–75, March–June 1948.

Volz, Horace S. Let's stop fooling around. Federal probation, 12:18–20, September 1948.

Von Domarus, Eilhard, M.D. Anthropology and psychotherapy. American journal of psychotherapy, 2:603–14, October 1948.

Waddington, Miriam. The student unit: some problems and psychological implications. Journal of social casework, 30:113–17, March 1949.

Wallinga, Jack V., M.D. Attempted suicide: a ten year survey. Diseases of the nervous system, 10:15–20, January 1949.

Walsh, Winifred. Residence clubs for adolescent girls. Child welfare, Child welfare league of America, 27:7–9, 14, December 1948.

The Washington school of psychiatry—training institution of the William Alanson White psychiatric foundation: addresses on the occasion of the 1948 convocation, October 9, 1948. Psychiatry, 11:i–xx, between p. 426 and 427, November 1948.

Welles, Barbara D. New ways in baby care. Parents' magazine, 24:27, 72–75, February 1949.

Whitman, Samuel. The responsibility of the local community for a mental-health program. Mental hygiene, 33: 51–60, January 1949.

Wiklund, Daniel. Proposal of the Swedish government committee for reform of the care of inebriates. Quarterly journal of studies on alcohol, 9:372–87, December 1948.

Wilder, Joseph, M.D. Psychiatry and economics. (Abstract.) American journal of psychotherapy, 3:102–17, January 1949.

Wineman, David. Group therapy and casework with ego-disturbed children. Journal of social casework, 30:110–13, March 1949.

Witmer, Helen L. Basic conceptions in social-work research. Mental hygiene, 33:108–14, January 1949.

Wittels, Fritz, M.D. Brill—the pioneer. Psychoanalytic review, 35: 394–98, October 1948.

Wittman, Phyllis, Sheldon, W. H., M.D. and Katz, C. J., M.D. A study of the relationship between constitutional variations and fundamental psychotic behavior reactions. Journal of nervous and mental disease, 108:470–76, December 1948.

Witty, Paul. On feeling at home in school. National parent teacher, 43: 12–14, February 1949.

Wolf, Anna W. M. Hero worship: wise or unwise? National parent-teacher, 43:4–6, December 1948.

Yoder, H. W. Moral and psychiatric evaluations. Journal of pastoral care, 2:1–5, Fall 1948.

Zimmerman, Frederic T., M.D. and Burgemeister, B. B. The effect of glutamic acid upon the mental and physical growth of mongols. American journal of psychiatry, 105:661–68, March 1949.

Zirbes, Laura. Why guidance? Childhood education, 25:197–201, January 1949.

Zucker, Luise. The use of the Rorschach test in an outpatient clinic. American journal of psychotherapy, 3:34–45, January 1949.